ABSTRACT

The Christian Medical Missionary's Response to the Health Needs of Northern Nigerian Women Due to Boko Haram Terrorism

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The Boko Haram terrorist group has negatively influenced women's health in Northern Nigeria, contributing indirectly to an increase in the prevalence of child marriage in the region, as well as kidnapping and assaulting women and their families directly. This paper examines Nigeria and its health concerns, including child marriage, and the history and activity of Boko Haram. Additionally, it poses three areas in which Christian medial missionaries may assist, based on Corbett and Fikkert's steps in community development after disaster: relief and rehabilitation, where the medical missionary interacts chiefly with victims of Boko Haram to aid in medical and spiritual healing largely through short-term mission work, and development, involving a medical missionary's interaction with the larger Nigerian community through and alongside traditional Nigerian healers for the benefit of Nigerian women as a whole. All the efforts of medical missionaries must be made alongside Nigerian women and the greater community, and medical missionaries must be careful to avoid paternalism or coercion in influencing individuals or the community. Utilizing Paulo Freire's theory of oppression, this thesis argues that Christian medical missionaries can aid women in relieving immediate medical needs, but will make more of an impact on an individual level by rehabilitating women victims of Boko Haram, and on a community level by empowering women through spiritual and medical support, for the betterment of Nigerian as a whole.

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THE CHRISTIAN MEDICAL MISSIONARY'S RESPONSE TO THE HEALTH NEEDS OF NORTHERN NIGERIAN WOMEN DUE TO BOKO HARAM TERRORISM

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TABLE OF CONTENTS

CHAPTER ONE

Nigeria, Boko Haram, and Women's Health Issues

Introduction

Boko Haram terrorism has deeply affected Nigerian women's health. Stemming from perceived government corruption, the terrorist organization has spread throughout northern Nigeria, and up into surrounding countries. Many health concerns affect Nigeria, including HIV/AIDS and malnourishment, and women's health concerns include high maternal and infant mortality and child marriage. Utilizing a three-tired method of aid, medical missionaries may work through relief, rehabilitation, and development, and medical outreach should strive to meet the physical, psychosocial, and spiritual needs created both my religious extremism and long-term cultural oppression.

Nigeria: Overview

Statistical Overview

Nigeria is Africa's most populous country, and the eighth most populous in the world. Home to 181,562,056 people, according to a 2015 estimate, Nigeria has a multitude of ethnic groups, but "the most populous and politically influential are: Hausa and the Fulani 29%, Yoruba 21%, Igbo (Ibo) 18%, Ijaw 10%, Kanuri 4%, Ibibio 3.5%, [and] Tiv 2.5%." Religiously, Nigeria consists of half Muslim, 40% Christian, and 10%

indigenous religions.[1] As of 2009, the average child ended his or her education after nine years of schooling, ten years for a male child, and eight for a female child.

General health concerns include a physician shortage, high HIV/AIDS prevalence and mortality, and malnutrition. There are 0.41 physicians/1000 people as of 2009, compared to the 2.45/1,000 people in the United States[2]. As of 2014, Nigeria was first in HIV/AIDS deaths in the world, with 174,300 deaths, second in total population living with HIV/AIDS at over three million affected people, but placed twentieth in total adult prevalence, adult defined as 15-49 years of age.[3] As Nigeria's median age is 18.2 years,[4] this may indicate that the majority of HIV/AIDS patients are children. Concerning malnutrition, as of 2013, 31% of Nigeria's children under five years of age were underweight, ranking twelfth in the world.[5] Clearly, there is a great need for medical intervention in Nigeria, especially in sexual health and nutrition.

Nigerian women face many health issues, including high infant and maternal mortality, and low contraceptive prevalence. The average age of woman at the birth of her first child is 20.3 (median: 25-29). Nigeria's maternal mortality is the eleventh highest in the world at 814 deaths per 100,000 live births, and their infant mortality rate is the tenth highest in the world, at 72.7 deaths per 1,000 live births. Contraceptive

[1] Central Intelligence Agency, "Nigeria."

[2] Central Intelligence Agency, "United States."

[3] Central Intelligence Agency, "References: Definitions and Notes."

[4] Central Intelligence Agency, "Nigeria."

[5] Ibid.

prevalence is only 15.1%[6] (the CIA defines this statistic as "the percent of women of reproductive age (15-49) who are married or in union and are using, or whose sexual partner is using, a method of contraception" which may be used as "an indicator of health services, development, and women's empowerment."[7]). Lack of sufficient health care services hinders women's progress toward empowerment, as women and their children face constant threats to their health welfare and cannot fight for their freedom from oppression.

International outreach of medical aid from religious and non-religious groups can help alleviate these health concerns, largely by providing more trained medical staff (a topic that will be discussed more fully in Chapter II). However, in the case of Boko Haram terrorism's effect on the women and children of northern Nigeria, Christian medical missionaries can offer a unique form of aid, as this paper will demonstrate.

Ethnicities, Northern Nigeria and Boko Haram

Much of the following argument is contingent upon understanding inter-cultural and inter-religion relations, and thus the main ethnic groups of concern in the Boko Haram attacks are summarized here. Northern Nigeria, the focus of this thesis, is populated predominantly by the "Hausa-Fulani" ethic group, and is largely Islamic.[8] Ismail H. Abdalla, in his book *Islam, Medicine, and Practitioners in Northern Nigeria*, distinguishes the Hausa people as living "mainly in north-western Nigeria and across the

[6] Ibid.

[7] Central Intelligence Agency, "References: Definitions and Notes."

[8] "Nigeria Facts."

modern border in Southern Niger." Abdalla uses a broad definition of the term "Hausa" as those who speak the language (Hausa), live in north-western Nigeria, practice predominantly Islam, and maintain Hausa "cultural traits a meaningful articulation of social interaction."[9] The BBC reports that in 2013, a state of emergency was declared in three northeastern states, Borno, Yobe, and Adamawa, where Boko Haram's influence was greatest. In these states, the Kanuri ethnic group predominates and most Boko Haram fighters are of this ethnicity, but speak Hausa.[10] Although Boko Haram most prevalently attacks northeastern Nigeria, and the Hausa originate in northwestern Nigeria, Hausa language and culture is highly influential in northern Nigeria.

When the British invaded in 1900, there were three main political groups in Northern Nigeria, divided linguistically: the Hausa- and Fulani-speaking people of the northwest, the Kanuri in the northeast, both influenced heavily by Islam. The third group, or the "Middle Belt," consisted of a multitude of different "pagan" ethnic groups, though some were part of Fulani emirates. Even before British influence, many of the groups intermingled in due to "intertribal wars, migrations, and the internal slave trade."[11]

The Hausa and Fulani merged over centuries of Fulani invasion and intermingling with the Hausa, and culminated in an Islamic jihad in beginning in 1802 in response to Islam's waning in Hausaland. The Fulani intermarried among the Hausa extensively, and the two groups are largely one larger group, as Hausa is now the dominant language and

[9] Abdalla, *Islam, Medicine, and Practitioners in Northern Nigeria*, 46.

[10] Chothia, "Who Are Nigeria's Boko Haram Islamists?"

[11] Coleman, *Nigeria: Background to Nationalism*, 20.

characteristic physical differences between the groups have dissipated. Although they remain concentrated in some areas in the northwest, Hausa-Fulani are found in many areas throughout northern Nigeria.[12] Smaller groups often became assimilated into the Hausa-Fulani,[13] and the Hausa contain a mixture of cultures and physical characteristics, linking largely by the Hausa language.[14]

This cultural mixing was perpetuated by British and Christian influences. As of 1958, three factors had played into mixing the varied groups of the "Middle Belt": the dominance of the Hausa-Fulani culture; British "pantribal federations" from historically separate tribal groups, intended to strengthen smaller groups against Hausa-Fulani political influence; and "energetic evangelization" by Christian missionaries.[15] For much of northern Nigeria, the Hausa-Fulani group has been politically and culturally influential, and remains a significant influence today (as indicated by the prevalence of Hausa language in Nigeria[16] and historical context).

The Kanuri group, however, resisted Fulani rule. Since their invasion into northern Nigeria in the thirteenth and fourteenth centuries and subsequent intermingling with the local peoples, the Kanuri have remained largely unified. They have been Islamic for many centuries, and they drew closer when Muhammed el Kanemi resisted Fulani

[12] Ibid., 21–22.

[13] Ibid., 20.

[14] Ibid., 20–22.

[15] Ibid., 24.

[16] Central Intelligence Agency, "Nigeria."

invasion in the nineteenth century.[17] The group speaks English (officially, as in all Nigeria), Kanuri, Hausa and Babur/Bura.[18] The Kanuri still reside largely within the Borno state,[19] one of the three regions most effected by Boko Haram terrorism.[20] As the Kanuri group has remained somewhat separate from the others, their maternal health practices differ from Hausa-influenced communities. However, this thesis focuses largely on the health needs of Hausa-Fulani communities, as they are a larger percentage of the population of northern Nigeria.

Boko Haram: Overview

History

Boko Haram is translated as "Westernization is Sacrilege" in Hausa, and was colloquially translated as "Western Education is a sin" over time. In Arabic, the group is called "amāʿat Ahl al-Sunna lil-Daʿawah wa al-Jihād" or "Association of the People of the Sunnah for Preaching and Jihad." The radical Islamic militant group, founded in 2002, has shifted focus from critiquing the Nigerian government to demanding Sharia law and seeking to "avenge" the death of their original leader, Mohammed Yusuf. The group's original "proclaimed intent was to uproot the corruption and injustice in Nigeria,

[17] Coleman, *Nigeria: Background to Nationalism*, 22–23.

[18] Mairiga et al., "Sociocultural Factors Influencing Decision-Making Related to Fertility among the Kanuri Tribe of North-Eastern Nigeria."

[19] Ibid.

[20] Chothia, "Who Are Nigeria's Boko Haram Islamists?"

which it blamed on Western influences, and to impose Sharīʿah, or Islamic law."[21] They began to perpetrate "assassinations and large-scale acts of violence" in 2009, according to the Encyclopædia Britannica, Westernization, to Boko Haram, clashes with Islamic teachings, and inspired government corruption and perpetuated widespread economic inequality throughout Nigeria.[22]

Boko Haram is a conglomeration of many different sects under non-central leadership, not all of which follow Yusuf's original doctrine. Boko Haram has been increasingly influenced by outside terrorist organizations, and "by 2013 some analysts began to see greater influence by al-Qaeda in the Islamic Maghreb in Boko Haram operations." The Nigerian government has since formed a Joint Task Force (JTF) and has included "vigilantes" in "its officially sanctioned civilian units," whose "extrajudicial killings of militants and civilians…may have galvanized support for the insurgents." Since then, Boko Haram attacks increased through 2015, even postponing the presidential election. As of February 2016, there have been 44,834 cumulative deaths due to Boko Haram. [23]

Causes of continued terroristic action include continued police brutality, Christian-Muslim tensions, and economic disparity:

> While Boko Haram cannot be neatly characterized as an insurgency or terrorist organization, its origins appear rooted in grievances over poor governance and sharp inequality in Nigerian society. "The emergence of Boko Haram signifies the maturation of long-festering extremist impulses that run deep in the social reality of northern Nigeria," writes analyst Chris

[21] The Editors of Encyclopædia Britannica, "Boko Haram."

[22] Ibid.

[23] Sergie and Johnson, "Boko Haram."

> Ngwodo. "But the group itself is an effect and not a cause; it is a symptom of decades of failed government and elite delinquency finally ripening into social chaos."[24]

According to the Council on Foreign Relations, Nigeria is "one of the world's poorest populations. An estimated 61 percent of the population lives on less than $1 a day."[25] In the northern part of the country, the area most affected by Boko Haram violence, 72% of the population lives in poverty. [26] The article notes that John Campbell, attributes this disparity, in part, to an imbalance of power in favor of "Muslim elites" who have "benefited from oil wealth at the expense of regional development." [27] [28]

Current Nigerian President Muhammadu Buhari declared in late December, 2015 that Boko Haram has been "technically defeated," as people have been able to return to their homes. He also stated that the group has been reduced to utilizing improvised explosive devices (IEDs) and recruiting young men. Critics question whether he has blown the Nigerian military's success out of proportion.[29]

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[24] Ibid.

[25] Ibid.

[26] Ibid.

[27] Ibid.

[28] Article references the following book: Nigeria: Dancing on the Brink, by John Campbell, *Nigeria*.

[29] "Nigeria Boko Haram: Militants 'Technically Defeated' - Buhari."

International Responses to Boko Haram

The US Department of State has designated Boko Haram as a Foreign Terrorist Organizations (FTO), and Boko Haram has associations "with links to al-Qa'ida in the Islamic Maghreb (AQIM)."[30] In a presentation to the US House of Representatives, Linda Thomas-Greenfield noted that there were "tenuous, but worrisome, and real" associations between Boko Haram and ISIL. She stated that there have been "2.4 million internally displaced people…and more than 180,000 Nigerians living as refugees in neighboring countries." She also stated that as Boko Haram has met opposition from surrounding Lake Chad Basin countries, their attacks have become more "vicious [and] asymmetrical…including the use of children as purveyors of deadly bombs." Thomas-Greenfield called for the world to respond to this crisis: "This is a global fight – it is not just a Nigerian fight."[31]

Boko Haram's efforts have reached Cameroon, Chad, and Niger. The United States sent military aid to help in the search for the Chibok schoolgirls, and France sent military advisors to Niger. Additionally, "The African Union authorized a joint force of 7,500 from Nigeria, Benin, Cameroon, Chad, and Niger to fight Boko Haram."[32] There is a deep need for aid in the fight against Boko Haram terrorism, and, as discussed more fully in the following sections, for medical care for the women victims of the group's violence.

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[30] Office of the Spokesperson, "Media Note: Terrorist Designations of Boko Haram and Ansaru."

[31] Thomas-Greenfield, Assistant Secretary, Bureau of African Affairs, "Boko Haram and Its Regional Impact."

[32] Sergie and Johnson, "Boko Haram."

Boko Haram and Women

Boko Haram has negatively impacts the health of many women in northern Nigeria. Although international recognition of Boko Haram's effects on women began with the Chibok schoolgirls' kidnapping, discussed below, Boko Haram has harmed many women physically, spiritually, and psychosocially through kidnapping, rape, torture, unwanted pregnancies, and forced religious conversion.

International Outrage: Chibok Schoolgirls

On April 14, 2014 Boko Haram attacked a school in the Borno village of Chibok, abducting 276 girls during their West Africa Examination Council exams. Later, 53 of the girls escaped their captors; 57 had escaped by April 2015. [33] The event generated a "global outrage" including the "#bringbackourgirls" campaign.[34]

A BBC News article reported that President Buhari stated that he would be willing to negotiate with "a credible Boko Haram leadership" regarding the release of the Chibok school girls. However, he said that he believed it was unlikely the terrorists would willingly negotiate with the Nigerian government. On the status of the Chibok schoolgirls, the BBC article stated the following: "The militants regard the girls as their most invaluable captives and their leader, Abubakar Shekau, said last year that most of

[33] Abubakar, "FACTSHEET: How Many Schoolgirls Did Boko Haram Abduct and How Many Are Still Missing?"

[34] "Nigerian President Offers Talks with Boko Haram over Chibok Girls."

them had converted to Islam and had been married off."[35] The schoolgirls are a small portion of the many women and girls that the terrorist organization has impacted. Testimonies from women survivors of Boko Haram camps give perspective into the lives of kidnapped women, and the problems they face upon return to their home communities. Although the fate of the Chibok schoolgirls is unclear, some of the following testimonies hint at their current situation, but give a largely picture of the nature of Boko Haram's impact on women's health.

Testimonies Regarding Women in Boko Haram Camps

The testimonies of women survivors recovered from Boko Haram camps have indicated that Boko Haram insurgency has influenced women's physical, psychosocial, and spiritual health. Dr. Fatima Akilu, head of the Nigerian "counter-violence and extremism programme," cares for approximately three hundred women and children, all "recently rescued" from Boko Haram camps.[36] She noted that her team (including several imams) remains vigilant for signs of "radicalisation" though they have, as of June 2015, the time of the article, seen none. Dr. Akilu stated that there had been accounts in which captives have "identified with their captors." She also stated that "beatings, torture, rape, forced marriages and pregnancies were common in Boko Haram camps."

The firsthand accounts of three women at Dr. Akilu's facility who "claim" to have been held in a Boko Haram camp alongside Chibok schoolgirls state that the women have

[35] Ibid.

[36] "Chibok Girls 'Forced to Join Nigeria's Boko Haram'."

been “brainwashed and are now carrying out punishments on behalf of the militants,” including slitting Christian men’s throats.

Physically, the women endured repeated sexual assault, and subsequent unwanted pregnancy. One woman, Miriam (her name had been changed for her protection), stated that when she and other captive girls refused to marry Boko Haram fighters, the insurgents brought murdered men in front of the girls, who then agreed to marriage and were repeatedly raped. "There was so much pain," she said. "I was only there in body… I couldn't do anything about it." Miriam was, at the time of the article, nearing the due date of her pregnancy by a Boko Haram insurgent. Testimony from another female survivor[37] indicated that women who refused marriage were repeatedly raped, and that some women complied with marriage to avoid rape. Finally, one woman stated that she married a Boko Haram fighter unknowingly, and that she would be giving her baby to her parents, and that she would marry again “if she finds the right man,” as her Boko Haram fighter husband “gave her permission” to marry again.

Psychosocially, home communities have refused many women victims, who have suffered brainwashing and psychological torture. Miriam stated that she hoped her baby was a girl, that she would “love her more” if the baby is a girl, and that she is “scared of having a boy." Miriam has been “rejected” by her community, and fears her husband’s return: “’People consider me an outcast,’ she said. ‘They remind me that I have Boko Haram inside me.’"[38] These women, and their fellow victims, lack a supportive home

[37] MCLAUGHLIN, “Kidnapped Chibok School Girls Now Fighting For Boko Haram, Former Captive Says.”

[38] “Chibok Girls ‘Forced to Join Nigeria’s Boko Haram’.”

community in which to heal from the atrocities committed against them. Regarding the psychological state of the Chibok schoolgirls:

> Anna said she felt no malice towards the girls she had seen taking part in the violence, only pity. 'It's not their fault they were forced to do it.' she added. 'Anyone who sees the Chibok girls has to feel sorry for them.' Exposing women to extreme violence seemed to be a strategy used by Boko Haram to strip them of their identity and humanity, so they could be forced to accept the militants' ideology.[39]

Faith, a sixteen-year-old Christian, was the third girl who claimed to have been in a Boko Haram camp with the Chibok girls. She stated that the Boko Haram men came in each morning and threw water on the girls to wake them to pray. They slit another man's throat in front of the girls. Faith stated that she saw at least one of the Chibok girls who had been married off to a Boko Haram fighter: "'She was just like any of the Boko Haram wives,' she explained. 'We are more scared of the wives than the husbands.'"[40] This implies that the women have been effected negatively psychologically, and implies that some women may have been indoctrinated into their captor's beliefs, or at least coerced into performing terroristic acts. These women victims have been forced to see and experience many inhuman tortures, and have been ostracized by their communities.

Additionally, many women have been forced to convert to radical Islam, creating a spiritual issue among female survivors. Anna, another woman held captive with some of the Chibok schoolgirls, stated that they were appointed as teachers, instructing other captive girls regarding recitation of the Koran, and "flogging" younger girls unable to

[39] Ibid.

[40] Ibid.

recite.[41] At least in this captive situation, these women have been forced to practice radical Islam, and enforce its mandates on other captives. Regardless of the women's original religion, this is a violation of spirituality through violence and coercion.

Child Marriage and Boko Haram

In addition to the health issues caused by religious extremism, traditional cultural oppression has influenced women's health negatively in Nigeria. One of the main structures contributing to negative health outcomes, especially for young women, is child marriage. Historically, African child-marriage and polygyny (polygamy in which one man is married to multiple women) have been practiced by non-Christians, mostly of the Islamic faith, in Nigeria and other parts of Africa. Originally, child marriage was between a young girl and a boy of comparable age, and the girl was sent to her husband's home when she reached eight or nine years of age to learn the "household duties of being a wife and mother." The age at which a girl is sent from her childhood home varies by region. Girls were traditionally not expected to consummate their marriage until they reached puberty, but in Nigeria, girls are now expected to engage in sexual relations upon marriage, regardless of age. Pregnancy at the onset of puberty, when the girl is still very young, brings "the likely consequences of risks to her health and possibly even to her life."[42]

Presently, in Nigeria, child marriage remains prevalent. Although it was outlawed in 2003, when marriageable age was set at eighteen, 17% of Nigerian girls are still

[41] Ibid.

[42] Macklin, *Ethics in Global Health*, 65.

married before fifteen years of age, and 43% are married by eighteen. The practice is more prevalent in the northwest where 76% are married by eighteen years of age. Child marriage has declined by 9% since 2003.[43] However, as discussed below, some sources indicate that Boko Haram terrorism has increased the incidence of child marriage in northern Nigeria.

According to Umma Iliyasu-Mohammed of Girl Child Concerns, a Nigerian NGO "dedicated to improving the lives of children, particularly girls, through improved educational opportunities,"[44] there is a possible link between terroristic actions of Boko Haram and an increase in child marriag. The attack on a school in the Chibok village that resulted in the kidnapping of "more than 200 schoolgirls" has partially inspired this movement.. She concludes that although the child-marriage usually results in the end of a girl's education, Boko Haram influence could present the reverse situation—"Unfortunately when families pull their girls out of school they take them back home, and when girls are at home the next thing will be marriage…"[45]

Additionally, Muhammad Inuwa Bello, argues that Boko Haram terrorism has encouraged northern Nigerian families to "prefer to marry off their daughters, instead of sending them to school and they fall victims to insurgents." Bello advises that families

[43] "Child Marriage around the World: Nigeria."

[44] "Girl Child Concerns."

[45] "Boko Haram Crisis Could Fuel Rise in Child Marriages - Activists | News by Country | Reuters."

educate their daughters to the Senior Secondary School (SSS) level to help them remain more eligible for employment to "develop the nation."[46]

Umma Iliyasu-Mohammed stated that northern Nigerian families fear Boko Haram and have begun to pull their female children from school for fear of their kidnapping, resulting in an increase in child marriages.[47] Uwais and Iliyasu-Mohammed both separately stated that increasing education among young girls decreases child marriage. Uwais emphasizes the government's preoccupation with Boko Haram and terrorism, as well as regional discrimination against northern Nigeria by its southern counterpart, as causes for lack of proper female education. She also stated the following regarding the Islamic faith:

> Northern politicians seem to think that taking a stand against pegging the minimum age for marriage would be synonymous with taking a stand against the Muslim faith. The religion has been misinterpreted to convey that child marriage is encouraged in Islam, whereas contextual interpretations would suggest the opposite…[48]

Thus, the issue must be seen as a complicated mix of Islamic and cultural traditions. Rather than focusing entirely on changing religious perspectives, influencing social environments, such as increasing women's empowerment through bettering health care services,, may have a large effect on decreasing the rate of child marriage in Nigeria.

Political corruption may also be involved in legislation surrounding child marriage. A north Nigerian senator, Ahmed Sani Yerima, married a 13-year-old Egyptian girl in 2010, and the article states that Yeriman, in 2013 "persuaded his fellow

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[46] "'Our Girls Marry Very Early because of Boko Haram.'"

[47] "Boko Haram Crisis Could Fuel Rise in Child Marriages - Activists | News by Country | Reuters."

[48] S and Clarke, "Nigeria."

Senators to defeat a motion that would have removed a constitutional loophole that means girls under the age of 18 are considered adults as soon as they get married." [49]

There are many financial and socio-political incentives for a girl's family to marry her off at a young age. Ruth Macklin, in her *Ethics in Global Health* argues that the direct financial gain from the "bride price" the husband awards the family is too small to be a large draw, but the indirect result of having "one less mouth to feed" incentivizes the family to give their daughter in marriage. However, Maryam Uwais, a northern Nigerian lawyer interviewed by the *Guardian*, stated "Child marriage is prevalent in many of the communities where poverty is endemic. Parents (and fathers especially) actually benefit from the dowry and extras that their daughter's suitor contributes to the family of the girl child."[50]

Nigerian women and girls remain stuck between child marriage and possible abduction and torture at the hands of violent, radical insurgents. According to the Human Rights Watch article "A Long Way Home: Life for the Women Rescued from Boko Haram," the Nigerian government was late in aiding kidnapped women.[51] According to the Nigerian military, as cited by the HRW article, rescue missions have resulted in over 1,000 recoveries. Yet these rescues, according to survivor witness testimonies, can result in more death—military vehicles run over and crush women and children in the chaos, and others are "caught in the crossfire."[52]

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[49] Ibid.

[50] Ibid.

[51] Avenue, York, and 1.212.290.4700, "A Long Way Home."

[52] Ibid.

Although a solution is still far away, Ifeoma Charles-Monwuba, deputy country director for Action Aid—an organization that "help[s] people use their own power to fight poverty and injustice. Because that's how real change happens – for families, for communities, for whole societies"[53]—suggested the importance of involving religious leaders in reforming educational (and subsequent child marriage) reform. She stated "child marriage was a cultural practice in Nigeria so it was vital to get traditional and religious leaders on board," and that her organization is working to aid Nigerian mothers gain employment to help pay for their daughters' education, as fathers may prefer to marry their daughters away, but a mother may strive to "keep her daughter in school for a little longer. "[54]

Therefore, for Charles-Monwuba, cultural (societal, traditional, familial, religious) sensitivity is necessary to effect change for child brides. Medical missionaries, may be able to work alongside cultural leaders in Nigeria to aid in the alleviation of women's health issues due to oppressive cultures and religious extremism.

Health Effects of Child Marriage

In her book entitled *Ethics in Global Health*, Ruth Macklin elaborates on the negative health effects of child marriage, declaring "The health consequences for girls and adolescent women put into marriage by their families are disastrous." Obstructed labor, due to "their underdeveloped anatomy," combined with the "stress on their bodies from pregnancy itself" endanger the young women's lives. Citing an African author,

[53] "Who We Are | ActionAid."

[54] "Boko Haram Crisis Could Fuel Rise in Child Marriages - Activists | News by Country | Reuters."

Macklin relays "The medical and social risks of pregnancy are greater for adolescents than for adult women. Rates of prematurity, low-birth-weight babies, maternal and infant mortality, anemia, and pre-eclampsia are dramatically higher for adolescent mothers."[55] Macklin notes that the majority of people in Nigeria do not have access to "Western-trained doctors" and are instead treated by "traditional healers and traditional birth attendants for medical care."[56]

Many of these traditional healers do not have adequate knowledge of female anatomy and perform a "blind incision in the anterior vaginal wall" during birth, referred to as the *gishiri cut*. This cut can cause "hemorrhage and death" or, more commonly, "in a remarkably high proportion of cases this incision cuts into the bladder, resulting in a permanent condition of leaking urine, known as *vesicovaginal fistula.*"[57] Macklin states that this condition often causes the woman to be expelled from her husband's home due to her smell, and she returns to her childhood home. Her parents, however, commonly refuse her due both to her condition and the unexpected "burden" of her unexpected return. These young women then rely on "begging and prostitution" to survive. Macklin warns against blaming this situation on the lack of aid:

> Although it is tempting to attribute this grim picture to a shortage of Western-trained obstetricians and lack of access of rural population to hospitals, a deeper explanation is more telling: the traditional practice of early marriage, payment of a bride price, and the cultural prohibition of allowing women to make their own choices about marriage or reproduction.[58]

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[55] Macklin, *Ethics in Global Health*, 66.

[56] Ibid.

[57] Ibid.

[58] Ibid.

Macklin argues that a culture, a society, a tradition, may be held accountable for actions against committed its vulnerable populations in its name. For the women in northern Nigeria, two cultures have collided: Boko Haram's radical insurgency that threatens to rape and torture women (and men) of all ages, and the traditional practices of their society that provides child marriage as a viable option for protection against this threat. In the meantime, rates of child marriage are increasing and Boko Haram continues to abduct and murder.

Two Sources of Suffering—Cultures Collide

Extremism and Oppression

In regard to women's health in Nigeria, specifically within reproductive and sexual medicine, there are two main principles that perpetuate suffering: oppressive cultural traditions, and religious extremism. The two principles are not mutually exclusive (oppressive societies necessarily breed more oppression and violence, which can lead to extremism), nor are their effects on the women of Nigeria wholly separate, but they must be individually addressed in the scope of medical missions to help foster lasting change.

The first principle relates to the long-term oppression that helped perpetuate child marriage and later create Boko Haram and. As previously noted, Boko Haram sprung from unrest due to a "corrupt" government—that is not to say that their actions are justified, as the widespread violence and torture they instigate in the name of this cause is not perpetrated in a just way against oppressors (nor would this form of violence and torture be just even if directed entirely against oppressors), but in a way that hurts fellow

oppressed individuals. However, unjust rule did help create the environment in which some of the Nigerian population became sympathetic to Boko Haram's cause, enough to provide the terrorist organization with willing fighters. Again, although it does not justify what Boko Haram has done, it may also be noted that colonial efforts in Africa possibly exacerbated this oppression, which will be explored later.

Additionally, cultural oppression created the environment in which child marriage was considered an acceptable future for female children, once Boko Haram helped remove education as a means of occupation and betterment. If child marriage had not existed within Nigerian culture in the first place, female children would not be facing an increased threat of the practice due to Boko Haram terrorism. However, Nigerian culture is not to be condemned as a whole. This mistaken and prejudiced idea could lead to potential oppression from the party trying to "help" the situation. The patriarchal elements present in the society (and in so many societies, including the United States) should be eliminated, and a medical missionary may contribute particularly through women's empowerment in bettering health outcomes.

Second, religious extremism is an offshoot of this oppression, metastasis of a problem already present, but its effects are different and must be uniquely addressed in medical missions. Religious extremism creates a wound more quickly, as we have seen in the relatively short spread of Boko Haram's terror to thousands of people in a mere six to seven years of violence. Religious extremism perpetuates itself through fear, as denoted, obviously, by Boko Haram's distinction of a "terror" organization. This is largely due to the more violent nature of this extreme oppression—as stated above, Boko Haram has been responsible for the deaths of 44,834 people as of February 2016. Many

of the female survivors of Boko Haram stated that they agreed to marriages to insurgents because Boko Haram fighters murdered Christian men before their eyes. People can be influenced through fear and violence to act against their beliefs, and religious extremism capitalizes on this extreme form of manipulation. Cultural oppression may cause many deaths: it has assumably deeply contributed to the widespread lack of education, especially for females, in Nigeria, as well as many of sexual and reproductive health issues. However, terrorism's death toll is more concentrated, and, therefore, more scarring psychologically and socially. Medical mission work may uniquely aid victims of religious extremism by supporting Christian community as well as meeting medical, psychosocial, and spiritual needs. Especially within the "development" stage, outlined briefly in the next section, Corbett and Fikkert highlight the importance of Christian community through "supportive people" to aid by "coming alongside of materially poor individuals or groups to help them remove obstacles to change that they are incapable of removing on their own."[59]

How Can Medical Missionaries Help?

Christian medical missionaries can aid in the fight for women's empowerment through medical outreach addressing both religious extremism and cultural oppression. Utilizing Steven Corbett and Brain Fikkert's three-tiered structure for poverty alleviation as applied to medical mission work, missionaries can help repair the negative health effects of religious extremism through relief and rehabilitation work. Additionally,

[59] Corbett and Fikkert, *When Helping Hurts*, 2012 Chapter 10, Section: "Principle #1: Foster Triggers for Huaman Change."

medical missionaries can work through development to help empower women to move past the oppressive traditions.

When Helping Hurts

Brian Fikkert and Steve Corbett's *When Helping Hurts: how to alleviate poverty without hurting the poor-- and yourself* presents three distinct forms of "help" that apply to three different situations, but all add up to the overall development of the impoverished community:

I. Relief: Fikkert and Corbett define relief as the "urgent and temporary provision of emergency aid to reduce immediate suffering from a natural or man-made crisis." In this case, the provider often gives material assistance to the receiver, who is largely incapable of helping him or herself at the time.[60]

II. Rehabilitation: The authors state that rehabilitation "begins as soon as the bleeding stops; it seeks to restore people and their communities to the positive elements of their precrisis conditions." Fikkert and Corbett emphasize working with people "as they participate in their own recovery. [61]

III. Development: Fikkert and Corbett describe this as "a process of ongoing change that moves all the people involved—both the 'helpers' and the 'helped'—closer to being in the right relationship with God, self, others, and the rest of creation." In this, those who seek to aid must work *with* the

[60] Corbett and Fikkert, *When Helping Hurts*, 2009, 104.

[61] Ibid.

> people they are trying to help, rather than taking a more domineering role. The goal of development is to empower both the helper and helped, to move toward a better, more God-centered future in a way they have not previously experienced. [62]

As a community progresses from relief to development, Fikkert and Corbett note that the members of the community and those that come to aid them (the medical providers, in the case of the women's health crisis in northern Nigeria), both sides benefit from the progress, and grow closer to "God, self, others, and the rest of creation."[63]

This concept can be applied to the oppressive and Boko Haram crises for women's health: as medical providers meet the most pressing needs of victims of Boko Haram terrorism, they provide relief. As the community seeks to restore these victims to social interaction within the community itself, then these victims, and the community as a whole, begin to return to "precrisis conditions."[64] However, with development, medical missionaries can be involved in altering the nature of oppression in general that helped foster the Boko Haram crisis, and directly contributes to women's oppression through child marriage. This, essentially, moves beyond precrisis conditions to the betterment of the entire community, and is a goal for long-term medical mission work.

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[62] Ibid., 104–105.

[63] Ibid., 105.

[64] Ibid., 104.

Conclusion

Nigeria's Boko Haram terrorist organization was born as a response to government corruption, and has physically, psychosocially, and spiritually harmed women, both directly and through exacerbating already prevalent child marriage. Although Boko Haram has done the most damage in northeastern Nigeria, home to the Kanuri people, the Hausa-Fulani people group has great influence in northern Nigeria, and medical missionary efforts may work within their culture to aid women victims of Boko Haram violence. Utilizing Corbett and Fikkert's three-tiered structure of community aid, medical missionaries may have a unique impact on empowering women through medical outreach in relief, rehabilitation, and development.

CHAPTER TWO

Relief and Recovery: Response to Boko Haram

Introduction

Boko Haram and cultural traditions have negatively affected women's health issues through oppression. Utilizing Paulo Freire's theory of oppression, this chapter investigates the nature of oppression both in general and in Nigeria. Additionally, utilizing Freire's theory of oppression recovery, and Fikkert and Corbett's relief and rehabilitation, this chapter seeks to offer a medical missionary's response to the health effects caused by religious extremism. Although Boko Haram has affected many people, the victims of focus in this chapter are refugees in displacement camps, regarding relief work, and the women victims of Boko Haram recovered from insurgent camps, aided through rehabilitation work.

Symptoms of Oppression

What is Oppression?

Before the onset of any discussion of oppression, it is important to consider the its nature, such as that presented in Paulo Freire's *Pedagogy of the Oppressed*. Freire argues that oppressors create an environment in which the oppressed are necessarily dehumanized, and in doing so, the oppressors are themselves dehumanized.[65] This is

[65] Freire, *Pedagogy of the Oppressed*, 26.

apparent in the Boko Haram crisis—in committing these atrocities, they tell the people of Nigeria that they are expendable, fodder in pursuit of religious and political gains, and force the population to live in fear. Additionally, the fighters dehumanize themselves, as they become the monsters that children fear at night, the face of violent oppression, rather than that of liberation from unjust government practices, (as was their claimed first motivation for reform, in addition to implementation of Sharia law[66]). They dehumanize themselves as they dehumanize others.[67] To overcome oppression, the oppressed and the oppressors must regain their humanity.[68]

How did Boko Haram become an oppressive force itself? Freire also teaches that the oppressed can rise up from their oppression in a way that, in turn, makes them oppressors, rather than helping restore the humanity of both oppressed and oppressor.[69] This is essentially Boko Haram insurgency: the oppressed, rose up to fight against their oppressors, but turned their violence against their fellow sufferers (as is more fully examined in the next section). Boko Haram is now simply another form of oppression in Nigeria, perpetuating violence and poverty in the name of fighting against violence and poverty.

Perpetrators of Oppression in Nigeria: Internal and International

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[66] The Editors of Encyclopædia Britannica, "Boko Haram."

[67] Freire, *Pedagogy of the Oppressed*, 26.

[68] Ibid., 26, 38.

[69] Ibid., 26.

In addition to the more visible oppression of religious extremism in the Boko Haram crisis, many groups, both internal and external in Nigeria have perpetuated traditional cultural oppression. Four forms of oppression of interest to women's health and Boko Haram include the internal pressures of patriarchal tradition, government corruption, oil wealthy elites, and the external pressures created by colonial powers. Cultural tradition created the society in which female children have been married at increasingly early ages despite the consequences to their health. [70,71], Oil wealthy Muslim elites have perpetuated an imbalance of power in favor of "Muslim elites" who have "benefited from oil wealth at the expense of regional development." This imbalance helped create the environment in which Boko Haram was able to grow.[72] Government corruption and police brutality (such Boko Haram's original leader, Mohammed Yusuf's death in police custody,[73] and military violence against women in their recovery efforts[74]) have also exacerbated the divide between Nigerians and their government, and between Nigerians and one another. Thus, internal cultural issues, including traditional patriarchal culture, wealth imbalance, and government corruption helped create the situation in which women suffered and Boko Haram grew.

External forces also contributed to oppression in Nigeria. Anthony Kirk-Greene stated that colonial pressures, while trying to minimize cultural interference and allow for

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[70] "Boko Haram Crisis Could Fuel Rise in Child Marriages - Activists | News by Country | Reuters."

[71] Macklin, *Ethics in Global Health*, 65–66.

[72] Sergie and Johnson, "Boko Haram."

[73] The Editors of Encyclopædia Britannica, "Boko Haram."

[74] Avenue, York, and 1.212.290.4700, "A Long Way Home."

"native administration" on a local level, did meet some opposition from Muslims regarding the institution of Christianity and Western education in Nigeria. This was especially true in the northern part of the country, which grew less quickly than the southern Nigeria. Kirk-Greene notes that this is due to the lack of Western education and Christianity in the north as compared to the south, leading to poorer development and the "growing disparity between north and south [which] later caused political tensions." Also, a changing economy under new Western influence focused on cash crop production and limited those without access to these crops to migration and tenant farming, or education to become artisans or tradesmen. Additionally, northern Muslim leaders resisted Christianization, and throughout Nigeria, the British sought to keep groups separate from one another to prevent unified uprising. The "Nigerian system developed into a sophisticated form of local government" and Nigeria became independent in 1960.[75] However, as colonial powers spread Westernization and Christianity, both became lines of division between northern and southern Nigeria, largely through developmental disparity. These external colonial pressures on Nigeria likely helped to inspire Boko Haram insurgency, especially considering their rallying call that "Westernization is sacrilege" and their focus on eliminating Western influence, which the group blames for perpetuating "corruption" and "the wide gap between the many rich and the few poor."[76] These terrorists have aimed at destroying that which helped to create the widespread poverty their people face. However, this does not justify their actions: as will be discussed in the following section, the oppressed rising up against their oppressors,

[75] Kirk-Greene, "Nigeria as a Colony."

[76] The Editors of Encyclopædia Britannica, "Boko Haram."

and in turn, oppressing other people creates a perpetual cycle of oppression. Only through efforts to restore humanity may the cycle be broken.[77]

The Oppressed Overcoming Oppression

Contrary to what we might expect, the oppressed must be the ones to foster their own restoration. Paulo Freire argues that overcoming oppression lies in the "pedagogy of the oppressed, which is the pedagogy of people engaged in the fight for their own liberation." This requires the "critical intervention" of the oppressed, who must become "developers of this pedagogy… The oppressed must be their own example in the struggle for their redemption."[78] The "egoism" of the oppressors, those who created the environment in which the oppressed suffer, prevents them from being able to implement the changes necessary for liberation, because the oppressed would again be the "object" of the oppressor's "false generosity of paternalism", perpetuating oppression.[79] Freire offers two steps to completing this liberation from oppression: First, the oppressed must understand the reality of their oppression and "commit themselves to its transformation." Second, after the "reality of oppression has already been transformed," the pedagogy shifts from the oppressed to the population, leading to "permanent liberation" for everyone.[80]

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[77] Freire, *Pedagogy of the Oppressed*, 27.

[78] Ibid., 35–6.

[79] Ibid., 36.

[80] Ibid.

This is applicable in the medical missions field, especially when working with victims of Boko Haram terrorism and cultural oppression. Utilizing the two steps mentioned above, medical missionaries might work as "allies" [81] not leaders, of the oppressed in the fight against oppression. The oppressed must be the ones to lead the movement toward liberation, because they are the ones who know the most about the situation: "Who are better prepared than the oppressed to understand the terrible significance of an oppressive society? Who suffer the effects of oppression more than the oppressed? Who can better understand the necessity of liberation?"[82] The oppressed must be the ones to lead their own liberation, because they are the only ones who truly know the nature of their oppression, and are wiling, through "the praxis of their quest for [liberation], through their recognition of the necessity to fight for it…"[83] to work toward a better future for themselves and their fellow oppressed people.[84]

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[81] Corbett and Fikkert, *When Helping Hurts*, 2012 Chapter 10, Section: "Principle #2: Mobilize Supportive People" Corbett and Fikkert note that the National Circles Campaign refers to people in supportive, reciprocal relationships with the impoverished to move through the "development" phase of restoration.

[82] Freire, *Pedagogy of the Oppressed*, 27.

[83] Ibid.

[84] Corbett and Fikkert, *When Helping Hurts*, 2009, 43 Although the focus on this thesis is the oppression of material poverty, but that of Boko Haram terrorism on women, Corbett and Fikkert state that although the poor are not necessarily "inherently more righteous or sanctified than the rich," but that "for His own glory, God has chosen to reveal HIs kingdom in the place where the world, in all of its pride, would least expect it, among the foolish, the weak, the lowly, and the despised."

To avoid this "false generosity of paternalism,"[85] in which oppressors try to lead a liberation for the oppressed, medical missionaries, when "truly solidary"[86] with the oppressed, must be aware of the culture in which they work, actively rejecting xenophobia, but maintaining Christian values. Different cultural practices are not wrong because of their difference, but practices that contradict Scriptural teachings are wrong. For example, child marriage is a cultural practice, and it is not bad because it is different, but because it involves actively treating people differently, and harmfully, because of their gender. In light of Galatians 3:28 "There is neither Jew nor Gentile, neither slave nor free, nor is there male and female, for you are all one in Christ Jesus,"[87] this practice is wrong because it does not act in the spirit of "all one in Christ Jesus," but oppresses women. With a Christ-like love for all people, medical missionaries may work through relief, rehabilitation, and development (and especially the latter two) to help the Nigerian community, and its women and children victims of Boko Haram. Together, the victims and missionaries may move past the atrocities of terrorism and oppression into a new, move liberated and healthy Nigeria.

Relief

Medical mission work is least uniquely helpful in the relief stages of community aid, in relation to Boko Haram's religious extremism. Medical missionaries can help by providing material relief (such as food and water) and professional medical aid.

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[85] Freire, *Pedagogy of the Oppressed*, 36.

[86] Ibid., 27.

[87] *Bible, New International Version* Gal 3:28.

However, their work as missionaries, so far as helping to open people to Christ's love and creating persistent Christian relationships, may be limited in the sheer volume of immediate medical needs.

Boko Haram's Public Health Consequences

Nigeria, as a whole, is suffering under Boko Haram's oppressive violence. In addition to the increase in incidence of child marriage, the group's actions have caused large public health concerns in need of immediate international response. One BBC article states "widespread" incidences of "malnutrition, malaria and other infections" have overtake a refugee camp outside the city of Dalori. The "camp clinician" Noah Bwala stated: "This is by far the worst thing I have seen in my life."[88] An article published in March, 2015 stated that unpublished "reports on the ground" name diarrhea as the most common problem in these refugee camps, with two unconfirmed outbreaks of cholera as of March, 2015. Most "internally displaced" peoples must retrieve water from natural sources, such as streams. "In our experience of the Malkohi camp in Adamawa, for example, about 50 cases of diarrhoea occur per week in a population of about 1000 people. Respiratory tract infections rank second, with about 30 cases per 1000 people per week."[89]

Additionally, there has been a measles outbreak (as of March 2015, the date of the article, "hundreds" of cases had been reported). Malaria is also widespread, but often misdiagnosed as "fever" (due to a lack of "qualified health worker[s]"). The article states

[88] "Surviving Nigeria's Boko Haram."

[89] Ibid.

that generally only patients with wounds of higher morbidity tend to present for medical aid, and thus the proportion of those with an injury is difficult to ascertain. The article states that according to their "experience," a fifth of the population is malnourished, and fatalities in childbirth are due to excessive bleeding caused by "risky conditions." HIV is reportedly spreading, and chronically ill patients (such as the hypertensive and diabetic) "have been off medication for at least 3 months."[90]

The authors noted that the Nigerian resources and those of surrounding countries are insufficient for meeting the needs of so great a public health threat, and calls the international community to action: "In the short term, health workers and health supplies, including vaccines, need to be deployed to both official and unofficial camps. In the long term, efforts should be focused on how to reintegrate returning refugees, and on building capacity for early preparedness for future humanitarian emergencies in Nigeria. The public health implications of the insurgency are dire, and the world cannot afford to sit by and watch."[91]

These public health concerns in refugee camps fall largely under the umbrella of "relief" as they are immediate needs caused by a man-made crisis that can be helped largely by direct contribution of material goods, such as the need for clean water and food. In terms of medical care, these crises can be helped largely by the addition of skilled medical professionals in these camps, with medical supplies, to meet the needs of these thousands of displaced people. Additionally, although the oppressed should be directly involved in fighting their own oppression this dearth of medical supplies and aid,

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[90] Ibid.

[91] Omole, Welye, and Abimbola, "Boko Haram Insurgency: Implications for Public Health."

and high mortality in their absence, necessitates direct intervention, rather than community-based interactions. Corbett and Fikkert state that it is important to involve people in the process of alleviation when they have something to contribute.[92] Nigeria, and its neighboring countries, cannot provide enough, and thus it becomes necessary to give, as they cannot do so themselves, and have provided what they are able. However, providers should seek to serve as the local community requests, filling in where local resources have been insufficient, rather than forging new, potentially harmful, avenues.

Medical Missionary Response

Medical mission work, in this case, may not be wholly necessary, though medical missionaries, as trained medical professionals, would be able to help greatly in the fight against these epidemics. As these needs are largely due to a lack of materials and professional help (such as clean water, food, and medical supplies and workers), any humanitarian aid, from government, international, for- or non-profit organizations, religious or otherwise, can largely meet them. Medical missionaries can contribute with their skills as doctors, nurses, dentists, etc., but the missionary aspect of a medical missionary's work, in the immediate danger of death due to illness and malnutrition, should be less of the medical missionary's focus than meeting physical needs. This is not to say mission work is not legitimate or necessary in times of crisis, and other missionaries may make great headway in being used by the Holy Spirit in these refugee camps in this time of disaster, but *medical* missionaries can better serve this group of individuals, those displaced with immediate and curable health concerns, by using their

[92] Corbett and Fikkert, *When Helping Hurts*, 2012, 106.

expertise as medical professionals. These medical mission trips would likely be short-term, spanning the length of the immediate crisis, and would have a more "bandage" effect to use Fikkert and Corbett's metaphor. This work would be less concerned with empowering the oppressed to work for their liberation and more focused on keeping vast numbers of people from dying from immediate, treatable conditions. When this group of people has been stabilized, when their life-threatening needs have been met, then rehabilitation and development can begin. Medical missionaries who have the opportunity to stay and participate more in the "pedagogy of the oppressed" in longer-term recovery may then work as missionaries and medical professionals simultaneously, as explored more fully in the next section.

Rehabilitation

Medical missionaries may aid in rehabilitation, or "[restoring] people and their communities to the positive elements of their precrisis conditions"[93], when they aid the women victims of Boko Haram insurgent camps. Though there are many different communities that could benefit from medical missionary rehabilitation efforts, as concerns women's health, this thesis focuses on victims recovered from insurgent camps. These women have undergone physical, psychosocial, and spiritual torture, as described

[93] Ibid., 104.

in the previous chapter,[94] and medical missionaries may be uniquely sorted to assist in returning women to the "positive aspects" of their original communities.

Boko Haram and Female Survivors of Assault

As noted in the first chapter, women who have been captured by Boko Haram experience beatings, rape, torture, and unwanted pregnancies, among other scarring situations.[95] These survivors and their children are also in need of immediate relief including food, water, and medical care[96] that can be met by many humanitarian aid organizations. However, medical mission work could have a unique impact on the lives of these women by helping women cope with these injuries by facilitating community among and within the group of victims and their children. Using Christian medical aid to bring about a woman's healing as a whole person, with the support of other women who can empathize with her situation, and a Christian community to support her spiritual needs, could help foster her return to the larger community. Thus, medical *missions,* as well as medical aid, become imperative during the process of rehabilitation, or the progress toward "precrisis conditions," because a medical missionary could serve both physical and psychosocial needs, and spiritual needs.

First, a diversely trained medical missions team could meet the varied needs of these women victims. To help bring about full physical and psychosocial recovery for these women, an interdisciplinary team including physicians, nurses, dentists, psychologists, social workers, and more would be most effective. Medical missions

[94] "Chibok Girls 'Forced to Join Nigeria's Boko Haram'."
[95] Ibid.

[96] "Surviving Nigeria's Boko Haram."

teams without these experts would need to create community partnerships with local professionals to fill these gaps. Specifically, Corbett and Fikkert note the importance of asset-based community development (ABCD) in which hinges on the belief that "God has blessed every individual and community with a host of gifts," and encourages "outside" resources to begin with the question "What gifts do you have?" rather than focusing on what the community needs. This "affirms people's dignity and contributes to the process of overcoming their poverty of being."[97] Additionally, it would be beneficial to include local missionary or faithful professionals in these medical efforts, to lend a greater cultural awareness to medical missionary work, and to establish better long-term success (note, again, Freire's statements regarding the importance of the oppressed leading the fight for liberation, due to their unique perspective into their oppression[98]). The goal of long-term mission work should be to create lasting relationships and Christian communities to fulfill Christ's call to "make disciples of all nations."[99] Therefore, including as many local and consistent people as possible in this effort would be beneficial in creating a lasting network of Christians who support and nurture one another, especially victims of assault who require new community as they have none of their own, as explored below.

Once their immediate health needs are met, the women victims of Boko Haram face challenges integrating back into their communities, creating the social component of their oppression. Consider the women of Dr. Fatima Akilu's facility: "Many fled

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[97] Corbett and Fikkert, *When Helping Hurts*, 2009, 126.

[98] Freire, *Pedagogy of the Oppressed*, 27.

[99] *Holy Bible, English Standard Version* Matthew 28: 18-20.

captivity, only to discover that some or all of their family members had been killed by Boko Haram. Others have been cast out from their communities, who now consider them 'Boko Haram wives'." Miriam, one of the women, stated that she hoped the baby she was carrying was a girl, that she was "scared of having a boy" and would love the baby more if it were female. Her community rejected her upon her return: "People consider me an outcast," she said. "They remind me that I have Boko Haram inside me."[100] Primarily, these women are now considered tainted in their own hometowns, by the people they once knew and interacted with daily, simply by association with Boko Haram fighters, of whom they are victims. These women face further victimization at the hands of their community, as lack of community support for their families and for themselves could leave them vulnerable to future attacks by Boko Haram.

Christian medical missionaries can help women discover what they need to restore themselves to the communities they came from, join local Nigerian communities, or to create new communities with one another. Christian medical practitioners, especially female doctors, nurses, etc., will be able to serve the women's reproductive and sexual health needs in an environment that is less frightening to female survivors of sexual assault. Additionally, by living alongside the victims, truly building a community in which individuals know one another on a personal level (rather than the more separated roles of doctor and patient in which the doctor maintains the majority of the decision-making power due to his or her more extensive medical knowledge, and the patient is asked to divulge personal information, without reciprocation), medical missionaries are able to more fully serve their patients in both the physical and spiritual

[100] "Chibok Girls 'Forced to Join Nigeria's Boko Haram'."

sense, because they live as equals, or brothers and sisters in Christ. Consider the actions of female nurses in a leper colony in northern Nigeria during Nigeria's late colonial period, 1920-1940. Women faced separation from their children due to disease, and the female Christian missionaries worked to create a safe, supportive environment for the women whom they served:

> Women faced unique hardships in that medical officials and missionaries sought to isolate children – both infected and healthy – from parents who had the disease. Although mothers allowed their babies to be weighed and examined, they resisted being separated from them. To remedy this situation, European and American nursing sisters occupied themselves with developing closer relations with women and young children. Their duties specified visitations with women, attendance at deliveries, and playing with children.[101]

These Christian women strove to become part of their patients' lives, and, in turn, provided a community for afflicted women. They sought to learn about the women and about their children, to spend time with them outside of strictly medical situations, and thus were able to provide better medical care for the women and children. This can also be applied, broadly, to the religious sense, or the "mission" work of the medical missionary: getting to know each woman, girl, and child, listening to her story, hearing her pain, sharing when appropriate, will allow a more reciprocal relationship between the missionary and the women victims of Boko Haram. Fikkert and Corbett emphasize the reciprocity of healing in community building, the idea that we are all broken and thus all need healing; that we can help one another heal through our unique perspectives.[102] Christian missionaries should share the true nature of Christ by choosing to "love your

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[101] Hardiman, *Healing Bodies, Saving Souls Medical Missions in Asia and Africa*, 292.

[102] Corbett and Fikkert, *When Helping Hurts*, 2012, 106.

neighbor as yourself,"[103] and thus treat these women we would treat our neighbors and friends, sharing and receiving wisdom and love, and healing for our mutual brokenness. This practice, treating all women as equals, would not only help introduce these victims to an example of Christ's love, but also may aid in Freire's first step in the pedagogy of the oppressed: recognition of the reality of their oppression, and commitment to liberation.[104] In a Christian community where "all are one in Christ Jesus"[105] there is no room for oppression and alienation, and these women victims could grow to see themselves as more than objects for assault, and to work together to fight for their mutual liberation from these oppressive forces.

Ideally, this community would also foster relationships between the survivors, as well as relationships between missionaries and patients. This form of community, in which the afflicted support one another, could help prevent further exclusion from Nigerian society in a rehabilitation setting. If Nigerians help and support Nigerians, aided by Christian medical missionaries, then these women victims can create a community within and among themselves that can help make up for the one that they lost. This is an important difference from creating a colony entirely akin to the leprosaria—leprosy patients, due to the separation from the community as a whole that their colony provided, had sometimes "insurmountable" difficulty in phasing back into regular existence outside of the leprosarium itself, often due to having missed the "Muslim education" their fellow Nigerians received. Many lived a "migratory" life after their

[103] *Holy Bible, NRSV* Mark 12:31.

[104] Freire, *Pedagogy of the Oppressed*, 36.

[105] *Bible, New International Version*, Gal 3:28.

cure, and others returned to the leprosarium to work in the only community in which they could wholly take part.[106] A community in which Nigerian women help and support one another, a community run by Nigerians (aided by outside missionaries) alongside the victims of Boko Haram, would preclude the separation from regular Nigerian society, as it would be a facet of Nigerian society in itself. Therefore, the sort of community in which Christian medical missionaries could do the best work (and therefore the least damage) would be one run by and for Nigerian women, the oppressed setting the terms in their fight against oppression, with Christian medical missionaries there to advocate for their fight.

Medical missions, in this setting, would serve as part of the support system in this rehabilitation community, rather than as the central force making decisions for the facility and the women, as was the case with the leprosaria. This could help foster the continuation of Nigerian culture and society for the women, rather than isolating them within a Western, Christian context entirely and furthering social ostracization. One element would remain similar between the leprosaria and these communities of survivors: Christian witnessing would be a large part of the medical missionary's contribution to the healing of the afflicted. However, as noted in the accounts of the leprosaria, this reverence for God can be a uniting factor within the community, even between religions:

> Missionaries stressed that religion especially was a matter of personal choice for all and was not a bar to presenting a Christian witness successfully through medicine. Indeed, Helser remarked that 'Mohammedans and pagans alike rejoice to see the power of God manifested through science and beyond science in the cleansing of the lepers.'…Dr Harris admitted that the missionaries had conformed their expectations somewhat to the setting: 'In accepting the restricted work

[106] Hardiman, *Healing Bodies, Saving Souls Medical Missions in Asia and Africa*, 297.

> phase of testimony as found in a Moslem leper colony, we have learned to be satisfied with quality of growth of the individual Christian.[107]

In seeing the work of God in restoration of the health of the women and children victims of Boko Haram, the reversal of malnutrition, the healing of wounds, and healthy births, people of all faiths may be brought closer to God and to one another.

Christian medical missionaries can aid in the rehabilitation of women and child victims of Boko Haram through supporting and serving through medical aid while witnessing the Christian message, respectful of Muslim beliefs. This method of rehabilitation, building a community in which Nigerian women and medical missionaries are all treated as equals, where the Nigerian community makes decisions, rather than the external, Western, Christian missionaries deciding a strategy of care for the Nigerians without their input, would allow both aspects of Jesus' two most important commandments:

> One of the scribes came near and heard them disputing with one another, and seeing that he answered them well, he asked him, "Which commandment is the first of all?" Jesus answered, "The first is, 'Hear, O Israel: the Lord our God, the Lord is one; you shall love the Lord your God with all your heart, and with all your soul, and with all your mind, and with all your strength.' The second is this, 'You shall love your neighbor as yourself.' There is no other commandment greater than these.[108]

With reverence toward God for the acts of grace and healing witnessed among the community, especially within a medical context in which people are more prone to notice and praise God's intervention, will foster love for God among Christians and members of all faiths. Hopefully, through example of Christ-like service from the missionary medical

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[107] Ibid., 295.

[108] *Holy Bible, NRSV* Mark 12:28-31.

staff, those who are not Christian may be introduced to Him, and those who are may be fostered in their growth. The second commandment, "to love your neighbor as yourself," would be fulfilled in both service and interaction between missionaries and the women and children they serve, and between the patients themselves. Rehabilitation of this kind cannot happen in "short-term" mission work, but requires the direct involvement of individuals concerned with personal and community growth and healing. Overall, this sort of community could help direct both the medical providers and the victims of Boko Haram toward God, and help in rehabilitating both the women and their community.

Conclusion

Oppression, in terms of Paulo Freire's *Pedagogy of the Oppressed*, is the act of an oppressive force dehumanizing other members of society, and therefore dehumanizing itself. Boko Haram is an oppressive force, and the product of larger oppressive influences that have plagued Nigeria for centuries. Freire argues that the oppressed must rise up against the oppressors and restore humanity to themselves and to their oppressors, for the benefit of the population as a whole. Christian medical missionaries may add to this struggle as advocates alongside the oppressed women and children victims of Boko Haram, largely in the act of rehabilitating women and their communities by fostering reverence for God and for one another, regardless of religious differences. These Christian communities would meet both health and spiritual needs, largely in building new communities for women who have been rejected by their own. These Christ-centered communities should be run by Nigerians and integrate as many local personnel as possible to support the long-term efforts of these Christian and patient-professional

restorative relationships. These efforts may begin to fulfill the first of Freire's principles of oppression recovery: recognition of oppression (through the Christian example of treating everyone as "all on in Christ Jesus"[109]) and commitment to liberation (as would be fostered in a supportive and loving community, where people recognize their own worth in God, and wish for the betterment of neighbor and self).

[109] *Bible, New International Version*, Gal 3:28.

CHAPTER THREE
Development: Response to Oppression

Introduction

Paulo Freire's theory of oppression, as discussed in the preceding chapter, includes two steps through which the oppressed overcome oppression: first, recognizing their oppression and "commit themselves to its transformation." Secondly, the oppressed must act to bring about "permanent liberation" for everyone.[110] These principles are applicable to the "development" stage of a nation's progress, as defined by Corbett and Fikkert in *When Helping Hurts*, when the goal is to bring about a large change that brings people closer to God, themselves, others, and all of creation.[111] The second principle, action toward liberation, is primarily the focus of a medical missionary's work in development, largely through helping empower women to act in their own communities to better the health statuses of other women.

To bring about change for the betterment of the women and children of Nigeria, specifically those affected by Boko Haram and child marriage, one must understand the history of Islamic and Hausa (the dominant, though not the only, ethnic group in northern Nigeria) medicine. Although the Hausa do not constitute the entire population of the region, they are influential (see Chapter I). Therefore it is helpful, when considering current health care in Nigeria and its cultural basis, to consider the influence Islam has

[110] Freire, *Pedagogy of the Oppressed*, 36.

[111] Corbett and Fikkert, *When Helping Hurts*, 2009, 104–105.

had on their medical culture, and what cultural ideals have remained relatively untouched through religious changes. Utilizing this information, one may seek to understand which cultural traditions are most deeply rooted, which are subject to religious influence, and how this interaction affects the women of Nigeria, especially in light of Boko Haram terrorism.

Development, as compared to relief and rehabilitation discussed in the previous chapter, is an even more long-term goal, and requires greater input for success, including prevalence and diversity of health care professionals. Development, as applied to medical missions, should focus on community outreach, and the health status of a large group of women. To fulfill the call to action toward liberation, in this case, liberation for Nigerian women, medical mission work should have a broader scope. As such, development concerns the broader alleviation of the cultural oppression that caused Boko Haram and perpetuated child marriage, rather than focusing on victims of Boko Haram exclusively. For the purposes of this study, this broader culture is constricted to Hausa culture, but as the Hausa-Fulani are a large and influential ethnic group in northern Nigeria, studying the Hausa practitioners that participate in women's health still includes many women. Further research, however, could study women's health practices in Kanuri peoples, or in any of the smaller ethnic groups that also reside northern Nigeria, Essentially, the medical missionary's work in development focuses on working with the Nigerian community to change oppressive systems, such as some elements of Hausa culture in relation to women's helath, rather than meeting needs of individuals or small groups. Through medical outreach and mission work, a Christian health care provider

may work alongside the people of Nigeria on an individual level to create lasting change on a regional or even national level.

However, this work can only be facilitated through a careful understanding of the systems it is trying to alter. Therefore, the following chapter seeks to understand the many Islamic and cultural influences on Hausa medicine, so that medical missionaries may understand the nature of medical practice in Hausa-Fulani-influenced peoples. Medical missionaries, equipped with an understanding of cultural and religious practices in medicine, especially those concerning women's health, may become better equipped to both treat their patients individually and aid them in the movement toward greater empowerment for Hausa, or Hausa-influenced women and hopefully the reduction of oppression in Nigeria as a whole.

Nigerian Medicine--Background

Precursor to Hausa Medicine: Islamic Medicine and Women's Health

> The importance of conservatism as far as the history of Islamic medicine is concerned lies in the fact that it emphasized dependence on tradition to the exclusion of speculative thought or innovation.[112]

Ismail Abdalla, in his book, *Islam, Medicine, and Practitioners in Northern Nigeria*, explains that Islamic medicine, in the "height" of Islam was based largely on Greek philosophy and medicine, and although practitioners revered Allah for "no cure could be achieved without the Will of Allah." Islamic medicine was predominantly scientific, a "pragmatic empirical approach to healing," and practitioners were predominantly laymen. However, this type of medicine did not make it to Hausaland.

[112] Abdalla, *Islam, Medicine, and Practitioners in Northern Nigeria*, 74.

"Like most other aspects of Islamic civilization at its height it aged and weakened."[113] Now, Abdalla argues, Islamic medicine is charged largely with spiritual significance, as is Hausa medicine.

Abdalla distinguishes two predominant types of Muslim healers: the shaykh and the sharif. The shaykh, or "head of the sufi order," who is considered "always inspired in his actions, religious as well as temporal, by the *silsila,* (or connection between "the disciple" and "the Prophet") directed and controlled by this invisible mystical bond. "The shaykh can "cause himself to have dreams in which he could meet and communicate with the Prophet Muhammad and receive from him direct answers to any problem," including medical inquiries. Medical "advice and treatment, especially that which he shaykh took from the Quran or hadith, became doubly significant in the eyes of believers," due both to its "supernatural force it has as the actual word of Allah or his Prophet, and…because of the mystical power, or *Baraka* that came down from the Prophet through dreams or through the *silsila*." This became increasingly true by the end of the medieval period. Ahmad ibn Ali ibn Yusuf al-Boni of Algeria's writings concerning "the powers and the secrets of some Quranic verses and Allah's attributes became increasingly popular, and are still highly esteemed in Northern Nigeria."[114]

The other type of healer is the *"shurafa* (sig. *sharif*), an exclusive class of religious elite who possessed *baraka* by virtue of descent from the Prophet Muhammad." The shurafa are able to both "communicate with the supernatural" and "manipulate its

[113] Ibid., 54-55, 69.

[114] Ibid., 74–75.

forces for the benefit of the sick and the needy."[115] However, the shaykh remains siginificantly more important than the shufara in healing in northern Nigeria today. Even now, the shaykh "or his equivalent, the Hausa malam or religious scholar, remains to this day an important medical specialist among the Muslim Hausa…" Due to his greater emphasis on the word of the Quran, "written tradition of the Prophet, and pseudo-medical literature that became abundant from the twelfth century onward," the "Islamic medical tradition" the shaykh practices promotes more "continuity of medical knowledge and practice" than that of a *sharif*, whose medical practices may be based more on his "charisma."[116]

These two classes of Muslim healer share a deep spiritual influence, a centering on the teaching of Mohammed, and a strong sense of the supernatural. In relation to Christian medical missions, this becomes very important when interacting with patients within a community, Hausa or otherwise, influenced by Islamic medicine. When a medical missionary seeks to influence the health of a community, he or she must decide whether to do so through emphasis on the supernatural elements of healing (such as the mutual reverence for God's works, discussed in the previous chapter), or through an emphasis on the more objective, scientific medical benefits the missionaries bring to the community. Arguably, a medical missionary is enabled to do both: he or she is knowledgeable regarding health crises and conditions and is equipped to 1.) administer medicine effectively, in a way the community can objectively see the scientific process of healing (as was the goal of Islamic medicine at the height of Islamic society), and 2.) give

[115] Ibid., 75.

[116] Ibid., 76.

reverence to God in a way that emphasizes the importance of His hand in healing, His provision in supplying both the material elements of healthcare and the alleviation of suffering. In a way, Christian medical missionaries may provide a form of medicine very similar to that of ancient Islamic medicine, scientific and empirical while reverential to God. But, additionally, missionaries offer spiritual development and support to the community, in addition to praise. Through this interplay of objective and spiritual medicine, the Christian medical missionary may benefit the health of the community while appealing to the spirituality common to Islamic medicine today, and therefore reach both bodies and souls through medicine. However, the medical missionary must be prudent in sharing with the community. If pure scientific medicine will be more accepted than medicine with a Christian message, or if the missionary's life is threatened (Boko Haram has intentionally killed Christians for their faith), the missionary should be wise, and prayerful, in deciding the best approach to missionary medicine in that area.

Hausa Medicine

In addition to general Islamic medicine, Abdalla outlines the seven varieties of Hausa practitioners, many of whom have been directly influenced by the shaykh practitioner. Regarding Islam's entry into the region, Abdalla states that Islam grew only gradually in "Hausaland," and Islam's ability "to survive at all was due mainly to Islam's ability to compromise with local traditions." This mixing of tradition and Islam later created "syncretistic Muslim practices which the leaders of the jihad strove to purge."[117] Additionally, due to "Islam and commercial contact," Hausaland became "a center of

[117] Ibid., 51.

trade, industry, and in the long run, a place of intellectual activity," including medicine.[118] However, as noted in the discussion regarding colonial influence in Nigeria, the spread of Christianity and Western education more predominantly in the south left northern Nigeria somewhat behind. As the following passages will elucidate, similar to Islamic medicine defined above, Hausa medicine is also largely based in supernatural and spiritual elements.

The author defines two broad categories of traditional healers in Hausaland, namely the "herbalists" (those who "treat minor ailments with herbal medicine, or…practice limited surgery") and the "Intercessionists" who utilize more "supernatural" methodology in treatment.[119] Although there are seven specific kinds of healers altogether, I will focus the two most involved in women's health, the *ungozomai*, or midwives, who are herbalists, and the *yan bori*, or "spirit mediums," who are Intercessionists. A third variety, the *malamai*, or "Islamic scholars" I have already mentioned, as they appear congruent to the shaykh, and will do so only peripherally from here on, in relation to *yan bori*.

Hausa Medicine and Women's Health—Ungozomai

The *ungozoma* (plural: *ungozomai*) or midwife in Hausa culture is primarily "an indigenous Hausa practitioner. Midwifery is as old as the Hausa themselves." The author also notes that there is little literature on their general method of practice, as men, especially in "a conservative Muslim society" are "only vaguely aware of he procedure of

[118] Ibid.

[119] Ibid., 118.

child delivery and are not interested in knowing." Additionally, the *ungozoma* is "generally illiterate" and thus her practice does not benefit from the teachings of Islamic medicine. *Ungozomai* medicine is, therefore, "all purely Hausa." The *ungozoma* practitioner is "usually the oldest woman in the homestead or compound whose experience through the years with disease and cure makes her indispensable for the well-being of the members of the extended family. She is the first medical specialist to whom as sick mother, or the mother of a sick child will turn." The author notes that *ungozoma* medicine is comparable to "first-aid" and equitable to *boka* or *mai magani* medicine, two other distinctions of herbalist practitioners. However, if "serious complications" occur in childbirth, a malam (again, Hausa shaykh), or even *yan bori* practitioner may be asked to help. Abdalla notes that these complications are "not uncommon" when girls get pregnant in their first menstrual cycle. The most (possibly only) recognizably Islamic influence on *ungozomai* practice is the "seclusion" of the mother and child for forty days after birth. The practice of the *ungozomai,* however, "in Hausa society is among the medical practices least affected by Islam and Islamic medicine."[120]

Thus, *ungozomai* medical practice is influenced by patriarchal oppressive forces, both traditionally Hausa and Islamic, that prevent the spread of knowledge of female health concerns, to the detriment of women and girls. Instead, incomplete and potentially flawed knowledge is passed down among families, and health knowledge appears to be largely colloquial, rather than scientific. The oppressive construct of the Nigerian patriarchal society, therefore, leads directly to negative health outcomes for women by neglecting to study women's health, and failing to record midwifery practices for more

[120] Ibid., 131–133.

consistent treatment plans. Not every pregnancy is deeply affected by this oppression, but as Nigeria ranks eleventh in maternal mortality and tenth in infant mortality, the situation is very dire for Nigerian women and girls.

Midwives are largely a familial asset, and a woman's reproductive and sexual health needs appear largely to be met within her family. Consider the following theoretical situation in which a young girl goes to live with her husband's family very early on: The girl leaves her family home to live with group of people she does not necessarily know well. Expected to engage in sexual intercourse upon marriage despite her young age, the girl experiences sexual health problems and has no one to turn to for help, save the oldest woman in her husband's family, with whom she is potentially unfamiliar and uncomfortable. This could very well perpetuate fear and isolation among child brides, and lead to negative outcomes if the girl feels she must hide her health problems, particularly if she feels pressure to become pregnant. If she does become pregnant, the *ungozoma*'s lack of sophisticated medical knowledge can lead to situations in which a *gishiri cut* is performed and vesicovaginal fistula occurs, leading the girl to be cast out from her husband's family, and rejected by her own.

Medical Missionary Response to Ungozomai

Ungozomai, with their close connections within their own families, could be a large asset to the medical missionary's fight to help end oppression for women and girls in Nigeria. They are members of the oppressed (being a Nigerian woman) and a medical

missionary should align with them as "allies" [121] to liberate women through bettering health care practices. The *ungozomai* have access to all the women in their families, and therefore helping an *ungozoma* practitioner could positively effected the health outcomes of many other women.. If an *ungozoma* is open to being educated in Western medical midwifery, then the medical missionary can provide this educational service (this highlights the importance of a variety of medical professionals in medical mission work, including those specially trained in midwifery/women's health). Increasing the medical knowledge of the *ungozomai* can help more women develop sexually and give birth safely, even in situations of early marriage, and the overall benefit for the Nigerian women would be positive. Educating *ungozomai* may not be a direct blow to the cultural practices that perpetuate child marriage, but it will indirectly empower women through access to a higher quality of health care for themselves and their children, and, hopefully, to a greater feeling of safety within their homes and communities.

Additionally, if the *ungozomai* are open to learning about Christianity, they could help begin to foster a Christian community between the women and children of their homes. This community could benefit the women of the household in many ways in addition to increased medical outcomes, including better emotional and social support, especially for young wives and a general increase in feelings of self-worth in Christ. Especially in the secluded environents in which many Hausa women live (discussed briefly in the following sections), this community could be instrumental in helping women overcome loneliness and alienation, moving them toward the fight for their

[121] Corbett and Fikkert, *When Helping Hurts*, 2012 Chapter 10, Section: "Principle #2: Mobilize Supportive People" Corbett and Fikkert note that the National Circles Campaign refers to people in supportive, reciprocal relationships with the impoverished to move through the "development" phase of restoration.

liberation from this seclusion. Overall, these practices may help the *ungozomai* aid in liberation for oppression by increasing her medical knowledge and ability to aid the women of her household. More empowered by this increased security of health outcome, the practitioner, and the women of her household, may be able to recognize their worth in Christ and commit to action toward liberation. This action, lived out, could include *ungozomai* teaching fellow midwives modern midwifery techniques, creating a ripple effect in the betterment of women's sexual and reproductive health. If the *ungozomai* is open to Christianity, the same sort of effect could be seen spiritually, helping women from her own household and others grow toward Christ, and toward one another.

Hausa Medicine and Women's Health—Yan Bori

The cult of *bori* is considered relatively old, and is originated with ancient Hausa belief systems, pre-Islam. Although there are Muslim and non-Muslim (invented post-Muslim influence) spirits, all are considered pagan. *Yan bori* (singular: *yar bori)* are the "mediums" of the *bori* cult, and are Intercessionists. Their medical power is derived from the belief in *iskoki,* spirits who inhabit "an invisible replica of the human environment attack the person and penetrate the skin and so cause sickness or other troubles." Ancestral spirits or witchcraft can also cause spiritual unhealthiness, and *yan bori* medicine largely consists of ameliorating these spirits. *Bori* practitioners are usually women from the "lower social classes". There is some tension between Islam and the *bori* practice, not only in the breaking of Islamic laws (drinking beer or blood while possessed to appease the spirit), but, primarily, the acknowledgement of gods other than Allah. Thus, the other Intercessionist practitioner, the *malam*, does not lend the *bori*

practitioner the same regard she gives him. The *malamai* are the interpreters of divine Islamic law, and serve as "a spiritual leader, an educator, political advisor, judge, secretary, and practitioner all in one." Abdalla states that at the birth of a new Hausa child, the malam receives, names, and blesses the child.[122]

Despite the malam's greater respect throughout Hausa community, both the *yan bori* and malam practitioner may be consulted, as noted above in the case of complicated pregnancy. Their consecutive practices indicates that there is some mixing of Islamic and "pagan" religious practices among the Hausa people even today. Although prudence and respectfulness are essential, this could indicate that the Hausa people, or at least the women, who more frequently partake of *bori* practices, as described below, are open to spiritual influences other than Islam. However, *bori* practice is ancient and deeply ingrained into Hausa life, where Christianity is a newer, potentially negatively viewed religion (considering Boko Haram's hatred toward Christians and Christianity's place in diving the north and south regions of Nigeria in its colonial era, between 1900 and 1960). Regardless, this spiritual flexibility could represent an open door for a medical missionary to bring both medicine and Christ's message of salvation to the Hausa people.

Abdalla states that most Islamic medical writings focused on the health of the man, including his sexual health; writing on the female body and female sexuality were limited if not "accidental" when describing the male's experience. Therefore, despite the "men's objections," Hausa women often practice *bori* spiritual possession. As Hausa society became more urbanized, the author argues, women became more "secluded," and therefore the "division between the two sexes in medical practice widened

[122] Abdalla, *Islam, Medicine, and Practitioners in Northern Nigeria*, 135–140.

progressively…" Additionally, "competition between co-wives and the great desire to have children" influenced Hausa women to pursue *bori* practices, as does the emotionally therapeutic aspect of the practice:

> It provides them with a ready socially accepted outlet for anxiety and fear, and at the same time equips them with the necessary protection and medicine against all possible and unpleasant events. Whatever reasons women have for joining the *bori* cult, it seems to offer tem compensation for the neglect, often deliberate, they suffer under the male dominated, male oriented Hausa Muslim therapy.[123]

Despite this, as the *yan bori* and *malamai* often serve the same families, the *malam* practitioner will have the final say over therapy—he is the mediator between Muslims and Allah, and Muslims with one another.[124]

The work of the *yan bori* is potentially detrimental to the spiritual health of the women and girls who participate in *bori* practices. Regardless of the validity of the claims to spiritual possession, these women and girls are seeking a connection to a higher power that is largely unfulfilled, and they are driven to this particular form of spiritual exploration by the patriarchal society that isolates them, providing this *bori* cult practice as the "socially accepted" outlet for their everyday anxieties. This is an unhealthiness of the spirit, caused by oppressive isolation, that will likely perpetuate these anxieties, rather than mending them, as the *bori* practices are, necessarily, hollow if not actually harmful. This spiritual ignorance can cause a spiritual *gishiri* cut, essentially leading women away from God, rather than pointing them toward Him (appeasing agitated spirits versus believing in an ever-present, all-loving God).

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[123] Ibid., 149.

[124] Ibid., 149–150.

Medical Missionary Response to Yan Bori

The *yan bori*, like the *ungozomai*, influence women's health in Nigeria due to patriarchal societal influences that create a need, in medical or spiritual knowledge, that these traditional Hausa-Islamic healers fulfill. While a medical missionary as a medical provider is able to better equip traditional midwives with medical knowledge (and spiritual knowledge, appropriately), the medical missionary as a Christian evangelist may be able to offer greater spiritual guidance to the *yan bori*. By spiritually guiding women and girls in these "isolated" societies, medical missionaries may be able to promote a movement away from using spiritual possession as an outlet for anxieties and a connection to the supernatural. With the *ungozomai*, where medical missionaries align with the practitioners, missionaries are working to increase the knowledge base from which the women work and the sense of supportive community within the household. In amending the lack of knowledge that leads to *yan bori* practices, a missionary's work would be largely evangelical, and therefore delicate care must be taken on the part of the missionary to include the *yan bori* as allies in the fight against oppression, rather than assuming a god-complex, or savior mentality through evangelical work. As God is true savior, and He does the calling to salvation,[125] and evangelizing to a *yan bori* practitioner (or any practitioner or Nigerian woman or person) should be largely based on trying to provide spiritual guidance to help foster the woman's hearing and accepting the call. As she is the facilitator of spiritual activities for many women in these communities, working

[125] *Holy Bible, NRSV*: "that is, in Christ God was reconciling the world to himself, not counting their trespasses against them, and entrusting the message of reconciliation to us."

to teach a *yan bori* medium of Christ's love could lead to the woman evangelizing to other women, or, at the very least, being less of a detriment to their spiritual health. The *ungozomai* practitioner, as well as the yan bori medium, may be able to fulfill this role of missionary to her own people, her fellow women, as both possess some status through their relationships with their families and those they serve.

However, if the *yan bori* practitioner is unwilling to change her spiritual practices (and all conversion should be, obviously, of the free choice of will), missionary outreach to *ungozomai* and the growth of Christian community can foster the spiritual health of the women to whom the *yan bori* practitioner administers her spiritual guidance, and could largely remove women's need for her practices (though it would be better to become allies with the women who are already serving as spiritual advisors to Hausa women). Changing the only cultural practice in which women are able to express their fears would be difficult, and arguably cruel, without Christian fellowship to replace it. However, especially in the turbulent times of Boko Haram terrorism, Christian fellowship may not be easily included into daily life. This difficulty, however, should not prevent Christian missionaries from striving to make God's word, His love and provision for any anxiety and fear, well known in the community of women and girls, facilitated by medical care. Motivating *yan bori* practitioners to help alleviate spiritual needs through fellowship with a loving and all-powerful God, rather than vengeful spirits, could help empower women to spread Christianity in their communities, and to grow as a society away from oppressive cultural traditions toward a more Christ-centered, loving, future.

Conclusion

Medical missionaries may work to serve both the physical and spiritual needs of the oppressed women and children of Nigeria, largely through interaction with local practitioners, such as the *ungozomai* and *yan bori.* This development, through and alongside the oppressed themselves, could help empower women to see themselves as deserving of higher worth and status than they currently possess, especially in the light of Christ's love for all persons, regardless of gender. Freire's first step in the oppressed fighting for their liberation would then be fulfilled—the oppressed become empowered as they recognize their oppression. Freire's second step, movement toward liberation, could be best administered through local practitioners to the women they have always lived alongside, as they know the culture and needs of the people and can most effectively work to create long-term support systems. The oppressed then are empowered to strive for their own freedom and that of the women in their community (and the greater Nigerian community as a whole), beginning with individual work of medical missionaries in empowering women with adequate reproductive and sexual health care, and the spiritual support to know that they are loved and worth as much as men.

Biblical Basis for Outreach

"The Great Commission"

> Afterward he appeared to the eleven themselves as they were reclining at table, and he rebuked them for their unbelief and hardness of heart, because they had not believed those who saw him after he had risen. And he said to them, "Go into all the world and proclaim the gospel to the whole creation. Whoever believes and is baptized will be saved, but whoever does not believe will be condemned. And these signs will

> accompany those who believe: in my name they will cast out demons; they will speak in new tongues; they will pick up serpents with their hands; and if they drink any deadly poison, it will not hurt them; they will lay their hands on the sick, and they will recover."
> *Mark 16:14-18*[126]

> And Jesus came and said to them, "All authority in heaven and on earth has been given to me. Go therefore and make disciples of all nations, baptizing them in the name of the Father and of the Son and of the Holy Spirit, teaching them to observe all that I have commanded you. And behold, I am with you always, to the end of the age."
> *Matthew 28: 18-20*[127]

In the Great Commission, Jesus charges His disciples with spreading the news of His resurrection to the earth to create more disciples, those who love and follow Him. This is essentially the first and foremost call to mission work: to travel far and wide to bring His children back to His great love. In Mark's version, Jesus specifically calls Christians to be healers in His name teaching that those who believe will be immune to poison and that people will be healed by the laying of hands. Especially in the last miracle, Jesus emphasizes the innate importance of healing in the call to missions. This healing is specifically miraculous, and not attributed to the intelligence or skill of men, but entirely the grace attributed to believers. Faith, not human ambition or education, simple belief in His rising, and the subsequent reformation of "unbelief and hardness of heart," precedes this healing. With God as the center of missions, combined with conversion and the story of the gospel, these healing miracles are listed as "signs" to "accompany those who believe" and are therefore meant to be part of the evidence for conversion.

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[126] *Holy Bible, English Standard Version.*

[127] Ibid.

This is consistent with Jesus' presence in human, bodily form for our salvation and the physical nature of many of His miracles (many healing and Lazarus' resurrection, for example)—Jesus communicates with those He wishes to bring to Him through the material world humanity lives in, often defying people's understanding of their own body's ability to heal and live and die to display God's command over nature, and His willingness (and perfect ability) to use this power for our good. Jesus' ability to overcome His body, overcome death, was the central argument for conversion—the resurrection, the defeat of finite nature and replacement with the power and wisdom of God, is what marked the salvation of mankind. When combined with medicine, mission work is called to simultaneously encourage people to return to God's love and to aid in physical ailments of the natural, human, finite body. Medical missions therefore hold a very specific niche—communicating God's love through healing the body, speaking in physical "signs" while sharing Jesus' resurrection and of His teachings.

Similarly, Christoffer Grundmann, in *Sent to Heal! Emergence and Development of Medical Missions,* teaches that historically medical missions have been disregarded as true mission work for a variety of reasons—in part due to the argument that sickness and health are all common experience of human life and are therefore difficult to attribute to the Christian God—and have been forced to defend themselves as missionaries.[128] Grundmann counters this by stating that medical missionaries have a special, unique position opposite the disregard attributed their profession, mentioned above. Grundmann argues that healing is an "expression of God's ongoing creative activity" and:

[128] Grundmann, *Sent to Heal!*, 201-2.

> …part of God's general revelation…this makes them, therefore, potentially means of a unique revelation…medical missionaries have the specific task of working across cultural boundaries in such a way that the *potential* revelation that is present in all healing becomes an *effective* revelation of God's will to save and heal individuals. Thus the unique message of medical missions is to show that God as revealed in Christ, now personally lays claim to this individuals' human being who seeks medical help and longs for healing, by now restoring and preserving this life from impending destruction.[129]

Combined in parallel with the argument for Great Commission's call to communicate through the physical body through miraculous healing to teach the gospel message, Grundmann's view that medical missionaries are able to create a personal bond between the Savior and the saved through the physical world elucidates a more complete image of a medical missionary as a disciple through which God may bring His children back to Him by means of a personal, physical and spiritual connection. This call binds Christian missions to reach out to northern Nigeria, within the culture of child marriage—if Christians are to go to the ends of the earth to bring the news of Jesus' resurrection, then they are certainly called to travel to Nigeria; if Christians are called to perform healing miracles as witness of God's power, then bringing the scientific and medical discoveries, testaments to God's miraculous work through all of creation, including science and medicine, certainly requires Christian outreach.

Jesus' parable of the Good Samaritan applies to the cultural-clash between (Western) Christian teachings and child marriage in Africa, and may also apply to the potential dangers of working in a war-torn region. In His call to missions, Jesus emphasizes the importance of following the teachings He gave the disciples and the

[129] Ibid., 202–3.

public before His crucifixion.[130] Luke 10:25-37 records the story of the "Good Samaritan," one of Jesus' parables regarding the importance of caring for one's neighbors. Primarily, an "expert in the law" asks Jesus what he can do to "inherit eternal life," to which Jesus replies "'Love the Lord your God with all your heart and with all your soul and with all your strength and with all your mind'[a]; and, 'Love your neighbor as yourself.'" Jesus continues, teaching of a Jewish man travelling between Jerusalem and Jericho who is captured, beaten, robbed, and left for dead. Two men, both leaders in the synagogue, see him and pass by. However, a Samaritan, historically of "low esteem" to the Jews,[131] stops and aids the man, caring for his wounds and carrying him to an inn, where he pays the keeper in advance for his further care, promising more funding upon his return. Jesus asks:

> "Which of these three, do you think, proved to be a neighbor to the man who fell among the robbers?" 37 He said, "The one who showed him mercy." And Jesus said to him, "You go, and do likewise."[132]

As Christians we are called to be the neighbor of members of other cultures, who have been rejected or mistreated by members of their own cultures. Although Christian beliefs may not coincide with the culture surrounding child marriage, Christian medical missions may be able to serve as a cross-cultural pathway by which to introduce the message of Christ while caring for the bodily wounds of child brides. The focus of medical mission work should be to make disciples through the help of medical aid, and freeing women from oppressive traditions, working alongside them in their fight for

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[130] *Holy Bible, NRSV* Matthew 28:20 "...teaching them to observe all that I have commanded you...".

[131] The Editors of Encyclopædia Britannica, "Samaritan: Judaism."

[132] *Holy Bible, English Standard Version* Luke 10:36-37; entire parable: v. 25-37.

liberation, building supportive Christian communities through medical outreach, can all serve as a beautiful example of God's love. This effort may help create disciples who spread this love throughout northern Nigeria, and beyond.

Also, if Christians are to "go and do likewise," then it should be without hesitation that the church lends aid to the widows and orphans of other religions and cultural backgrounds, even in potentially dangerous situations—the Good Samaritan stopped to help a man in who had been robbed, potentially exposing himself to the same strife, but he chose to help a fellow person rather than protect himself. The serpents of the Great Commission that Christian missionaries handle, rather than the literal snakes, may be war zones or cultural misunderstandings. Regardless, Jesus teaches that God will intercede for those who believe, for the benefit of spreading the gospel to all nations according to His plan.

Finally, Jesus' example provides further guidance for Christian medical missionary work in northern Nigeria within the realm of child marriage, pertaining to the spiritual needs of the child brides and women victims of Boko Haram who have been rejected by society. Mark 5:24-34 gives the story of a woman who had "been subject to bleeding for twelve years," and had paid all of her money to doctors, who had been unable to heal her—she had grow worse, rather than better. She believes that if she can "just touch his clothes, [she] will be healed." As Jesus passes by her the woman reaches out and touches his cloak:

> Immediately her bleeding stopped and she felt in her body that she was freed from her suffering.
> At once Jesus realized that power had gone out from him. He turned around in the crowd and asked, "Who touched my clothes?"
> "You see the people crowding against you," his disciples answered, "and yet you can ask, 'Who touched me?'"

> But Jesus kept looking around to see who had done it. Then the woman, knowing what had happened to her, came and fell at his feet and, trembling with fear, told him the whole truth. He said to her, "Daughter, your faith has healed you. Go in peace and be freed from your suffering."[133]

Jesus heals the woman, in a large crowd of people, and specifically works to know her personally, even if only for a moment. The woman's plight holds many parallels to that of the child brides, especially those who suffer from vesicovaginal fistula who are expelled from society, left with nothing, as the woman was left without financial resources at the very least. Jesus does not mention her social or cultural status at all, He heals her physical suffering, and, in turn, affirms that her "faith has healed" her. In this, Jesus directly connects the dual nature of physical healing and spiritual affirmation and growth. Just as the sick woman's bleeding, her "suffering," ended physically, she received confirmation from Jesus Himself that her faith had caused God to reach down and intercede for her in the physical world, and healed the broken body that no man had been able to heal. She received healing and assurance in the goodness and love of God—temporary and eternal relief.

This same principle may be applied to the child brides, and women victims of Boko Haram terrorism of northern Nigeria. As child brides, their bodies are not their own, their futures virtually sold for a small bride price and their families' financial relief. Upon marriage, even at very young ages, pre-pubescent in some cases, they are expected to fulfill the sexual duties of a wife, often to their physical detriment, and, although less quantitatively measureable, spiritual injury. Women victims of Boko Haram terrorism are also objectified, kidnapped like property and forced to sustain terrible physical and

[133] *Holy Bible, NRSV* Mark 5:30-34.

psychological torture, and, in some cases, convert to radical Islam, violating their bodies and spirits.

Medical missionaries may be able to open a door in the darkness some of these women endure—those who are forced into prostitution and begging due to vesicovaginal fistula, those who are captured and tortured by Boko Haram insurgents, those who are sold by their families to men who force them into pregnancies that directly threaten their lives, all of these women have a physical need for Western science due to the medical issues they face. Through the gift of medicine, given as the Samaritan gave, freely, generously, and selflessly, Christian medical missionaries may provide for the physical needs of God's children. Through providing the means for healing as Jesus did, with specific and personal connection and a desire to know His patient as a person, to look at her face in a crowd of people, despite the other work that called for Him, a medical missionary may also help provide spiritual guidance leading to reconnection with God. This connection, Grundmann argues, could provide the culture-crossing safety and comfort of knowing that there is an all-powerful God specifically concerned with *saving*, rather than breaking, her body, and her soul. Medical mission work in Nigeria may seek to provide this connection to God through empowering women and building supportive Christian communities. It is the duty of Christians to care for the suffering[134], and to make disciples of all nations, to use what we have been given to help the less fortunate,

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[134] *Holy Bible, English Standard Version.* Psalm 82:3-4
"Give justice to the weak and the fatherless;
maintain the right of the afflicted and the destitute.
Rescue the weak and the needy;
deliver them from the hand of the wicked."

and to engage as believers with those whom God calls us to serve, to learn from them as they learn from us.

CONCLUSION

Christian medical mission work may benefit women's health needs in northern Nigeria, especially regions effected by Boko Haram terrorism. Utilizing three forms of aid, relief, rehabilitation, and development, medical missionaries may work alongside the people of Nigeria to move past the effects of religious extremism and cultural oppression. Relief work would be short-term (spanning the length of the crisis) and largely medically focused, as Boko Haram terrorism has created many epidemics among refugee camps and medical missionary outreach may best serve immediate, life-threatening medical crises through material and professional outreach to support the resources of Nigeria and its neighboring countries. Rehabilitation work could be through longer-term interaction between medical missionaries and the female survivors of Boko Haram insurgent camps. A diverse team equipped to aid physical, psychosocial, and spiritual injuries may work alongside Nigerians to build a Christian community for these survivors, many of whom have been rejected from their home communities. Finally, medical mission work in development should consist of equipping Hausa practitioners, chiefly the *ungozomai* and *yan bori*, the two groups most closely associated with women's health in Hausa culture, to bring physical and spiritual healing to the women they live with and serve.

These efforts should be designed to "make disciples of all nations" through simultaneous physical and spiritual outreach. Medical missionaries should strive to show God's love through the miracle of healing, and to get to know the women they serve on a personal, individual basis through a reciprocal, neighborly relationship. Through these

interactions, northern Nigerian women may become more empowered through better health care, and through the example of Christ's love for all people, regardless of their gender. Working as allies in the fight against the effects of both religious extremism and oppressive patriarchal traditions, medical missionaries may help Nigerian women recognize their worth, and move toward liberation for themselves, and their sisters in community. Overall, medical mission work in northern Nigeria can help women's health and spirituality, serving body and soul, to glorify God by bringing His love to those who have been alienated and assaulted.

SUGGESTIONS FOR FURTHER STUDY

This thesis does not seek to offer a fully-formed methodology of missionary practice among the Hausa people. Further study could seek to develop a more practical application of the ideas given here, including the structures and functions of a missionary community for female survivors of Boko Haram and their children, and a methodology for interaction with *ungozomai* and *yan bori* respecting Hausa cultural parameters. Finally, further study is needed to consider developmental medical mission work among other ethnic groups in northern Nigeria, especially the Kanuri peoples of Borno state, that which is most heavily effected by Boko Haram terrorism. As their traditional medical practices are different, working within Kanuri culture to benefit women's health will be different than working with Hausa practitioners.

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