

# LOCAL REACTION TO BRITISH INTRODUCTION OF SCIENTIFIC MEDICINE IN SOUTHERN CAMEROONS

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Before colonialism, the Cameroonians lived a purely traditional life style from all perspectives. Their value for and efforts to obtain good health was webbed up in the practice of traditional medicine. Since traditional medicine preceded scientific medicine and the fact that the latter has been unable to cure certain diseases like epilepsy and madness, some scholars assume that the former is more efficient (Ernest Joh, *Traditional Medicine in Kom* (Bamenda: Unique Printers, 2006); Abraham Sindo, *Local Healers among the Ndop of Cameroon* (Buea: n.p., 2003). But the defectiveness of traditional medicine to understand and check the devastating effects of the epidemic outbreaks, which ravaged the territory in the 1920s and 1930s, brings such a conclusion to book by scholars (See Daniels Llyod, *The Scores of Scientific Medicine in Africa* (Nairobi: Eliot Publishers, 2008). who consider the fundamental role of scientific medicine in the eradication of such ailments with great admiration. However, the search for an effective effort to combat old and emerging diseases, and to sustain the people's response towards health related issues worldwide have put to birth another school which propounds the combination of both traditional and modern medicine as a recommendable solution to health problems. The paper falls in line with this idea. It argues that traditional efforts alone could hardly meet up with the health expectations of Southern Cameroons, and that the British effort of penetrating the region with scientific medicine is considered an awaited complimenting phenomenon. The paper, written on the basis of published and unpublished sources, with emphasis on archival and oral data, examines the practice of good health prior to colonialism, British efforts of penetrating the territory with European medicine and the people's reactions thereto. It also attempts to evaluate the people's position in relation to both traditional and scientific medicines in curing diseases.

**Keyword:** Local reaction, Britain, scientific medicine ,southern Cameroon.

## INTRODUCTION

Cameroon, located at the Eastward end of the West African coast-the 'hinge of Africa'-where the coastline turns south, came to be well known in the 19<sup>th</sup> century, from 1827, as part of the informal British Empire, although ironically, it was annexed by the Germans through the Germano-Douala Treaty of July 1884. The German annexation was unexpected, not only because the Germans had never before shown any interest in colonial acquisitions, but also because of the numerous publicised appeals by the local chiefs, the British Consular officials, missionaries and traders that Britain should formally take over the territory. (Ardener Shirley, *'Eye-Witnesses to the Annexation of Cameroon'* (Buea: n.p., 1988).

The German protectorate lasted for only 30 years until the outbreak of the World War I in 1914, but during those short years, the Germans: negotiated and established the country's international boundaries; set up the institutions of modern administration; and gave rise to the idea of belonging together or being a Cameroonian amongst the people of the various ethnic compositions and traditions states of the territory. An attempt by the Germans in 1911 to enlarge their original territory of Cameroon by squeezing out of French hand large portions of their Equatorial African possession was short-lived as the French re-annexed them to their original possession in 1916 following the results of the war. (Rudin, H. R., *Germans in the Cameroon, 1884-1914: A Case Study in Modern Imperialism* (New Haven: Yale University Press, 1969).

The allied victory in Cameroon and the expulsion of the Germans in 1916 was followed by the partition of the territory disproportionately between the Britain and France on one to four basis in favour of the latter. Any hopes the British had entertained during the occupation of the annexing, rather incorporating, their own portion of Cameroon into the neighbouring protectorate of Nigeria was shattered by the provisions of the Treaty of Versailles which made former enemy territories mandates of the League of Nations. The period of the British and French mandate in the two Cameroons lasted from 1922 until 1945 when the League of Nations (and its Permanent Mandate Commission which

supervised the administration of the mandate territories) was replaced by the United Nations and its Trusteeship scheme. The two territories became territories under the same administrative authorities. (Verkijika G. Fanson, "Anglophone and Francophone Nationalism in Cameroon" in *The Commonwealth Journal of International Affairs*, 350, 1999: 282)

By the term of both the League of Nations and the United Nations, Britain and France had full powers to constitute their parts of Cameroon into customs, fiscal, currency and administrative union of federation with adjacent territories, short of annexation, as already mentioned. It is for this reason that Francophone Cameroon belonged to the federation of French Equatorial Africa, but as a separate administrative unit. The tiny and geographically disjointed Anglophone Cameroon was treated by the British for the purposes as an integral part of British Nigeria. The northern strip of the Anglophone territory (British Northern Cameroons) was subdivided and fused with the administration of the three separate provinces of Northern Nigeria, while the southern part (British Southern Cameroons) (The terms Southern Cameroons and Anglophone Cameroon are used interchangeably in this paper, and all refer to the geographical coverage known today as the North West and South West Regions of the Republic of Cameroon) see map) became one of the administrative provinces of Southern, later Eastern Nigeria (Fanson, "Nationalism," p. 283.)

Francophone Cameroon became independent in January 1960 as *La Republique du Cameroun* after a gruesome anti-colonial struggle, although those who achieved or were accorded independence were not the central participants 'in the turbulent political conflicts and manoeuvres of the mid-1950s'. (Sir Reginald Coupland, *Welsh and Scottish Nationalism-A Study* (London: n.p., 1954), p. xix.)

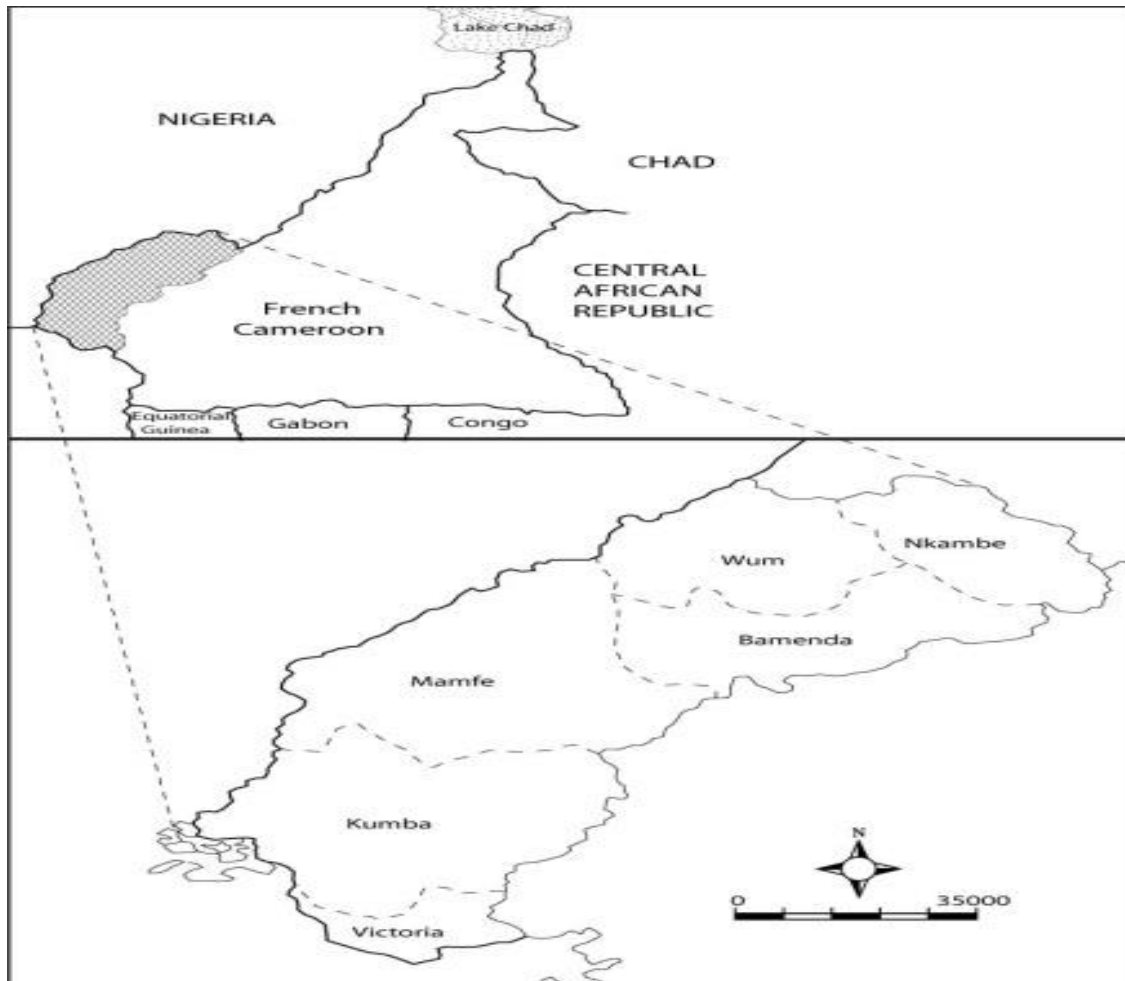
The people of Anglophone Cameroon, which at no time was treated as a single territory, had to decide their independence through UN-organised Plebiscites which were separate for the Northern and Southern Cameroons. The former voted to attain independence as part of Nigeria and thereafter became part of the Sardauna Province in Northern Nigeria while the latter voted to attain independence by reunifying with *La Republique du Cameroun*. After a Constitutional Conference in July 1961, the British and French Cameroons reunited on 1 October 1961 to form the two federated states of the Federal Republic of Cameroon, Anglophone Cameroon becoming West Cameroon and Francophone Cameroon becoming East Cameroon. In 1972 through a Referendum, it became the United Republic of Cameroon; and in 1984 it reassumed the *La Republique du Cameroun* appellation of Francophone Cameroon of 1960. (For more information about the political evolution of Cameroon, see Joseph B. Ebune, *The Growth Political Parties in Southern Cameroons 1916-1960* (n.p.: 1992). In fact, as the political statues of the territory changed with the passage of time, so were the health units established by the British administration and the people's attitude towards European medicine.

Before 1916, the presence of European medicine in Cameroon was not well known to the locals of Southern Cameroons. It was confined to German colonial administrator in the coastal area as a weapon of combating the harsh tropical climatic and insect world with which they were forced to live. After the partition of German Cameroon, the British military administration received no formal instructions from Nigeria or Britain on the establishment of medical posts in the divisional headquarters of the Southern Cameroons. But as early as 1916, medical posts which later became hospitals were established in the four divisions (By 1916, Southern Cameroons was divided into four divisions, namely Bamenda, Mamfe, Victoria and Kumba. But by 1960, the Nkambe and Wum Divisions had been carved out from Bamenda.) of the territory. Thus, the story of the introduction and penetration of scientific medicine into the Southern Cameroons (from the coast into the hinterlands) was the efforts of the British, through the colonial government, Native Authorities and missionaries of the mainstream denominations. Meanwhile the former handled health issues in urban centres, the latter two did so in the rural settings. Due to the complexity of this purely traditional setting where traditional medicine was *alpha* and *omega* to the people prior to British presence in the area, introducing and penetrating it with new medical perceptions and doings were not to be easy tasks. Consequently, the utilisation of different strategies by the diverse stakeholders to acquire the desired results was an issue of interest. For better understanding of the peoples' reaction towards European scientific medicine, a brief account of pre-colonial health care is important.

## 1. The practice of traditional medicine

The notion of good health during the pre-colonial era simply implied eating well and staying safe from deadly diseases. This knowledge, considered a societal value in its own rights, was gained through an informal continuous acquisition by children from parents often transmitted through observation, practice and/or formal lecturers. In consequence, the general public was relatively informed about good health, and tried every available and applicable method to stay healthy since they considered the knowledge and practice of good health as inseparable entities. (Interview with Paul Kajoh, 67 years, traditional healer in Mbem, Nkambe, 2 June 2009; B.K. Voh, 61 years, Chief of Nwa, Ndu, 3 June 2009.) No wonder, Shi, Fabricant and other (Shi Q.W.; Li L.G.; Huo C.H.; Zhang M.L.; Wang, Y.F. "Study on natural medicinal chemistry and new drug development" *Chin. Tradit. Herb. Drugs* 41 (2010), 1583–1589; Fabricant D.S.; Farnsworth, N.R. "The Value of Plants Used in Traditional Medicine for Drug Discovery, *Environ. Health Perspect.*, 109 (2010) 69–75.) comment that since prehistoric times, humans have used natural products, such as plants, animals, microorganisms, and marine organisms, in medicines to alleviate and treat diseases. According to fossil records, the human use of plants as medicines may be traced back at least 60,000 years. The use of natural products as medicines must, of course, have presented a tremendous challenge to early humans. It is highly probable that when seeking food, early humans often consumed poisonous plants, which led to vomiting, diarrhea, coma, or other toxic reactions

perhaps even death. However, in this way, early humans were able to develop knowledge about edible materials and natural medicines. Subsequently, humans invented fire, learned how to make alcohol, developed religions, and made technological breakthroughs, and they learned how to develop new drugs. Traditional medicines (TMs) make use of natural products and are of great importance. Such forms of medicine as traditional Chinese medicine (TCM), Ayurveda, Kampo, traditional Korean medicine (TKM), and Unani employ natural products and have been practiced all over the world for hundreds or even thousands of years, and they have blossomed into orderly-regulated systems of medicine. In their various forms, they may have certain defects, but they are still a valuable repository of human knowledge. This is the case with the Southern Cameroons prior to the introduction of modern medicine by the British.



**Figure 1:** Map. Southern Cameroons by 1961

Source: J.B. Ebune, *The Growth of Political Parties in Southern Cameroons 1916-1960* (Yaounde:CEPER, 1992),30.

The practice of good health entailed performing acceptable actions to stay free from or to cure sickness, and this meant a whole lot of procedure. In situations when all was well, the people, especially household and/or compound heads, offered prayers of protection to their ancestors against deadly deceases. Nonetheless, their human frailty authored their habitual assistance sought from sorcerers to decipher what illnesses awaited them, and how they could be averted. But, the visitation of diviners(The devices employed during the process of divination by the diviner were very much determined by the nature of each case presented to him. One of the devices involved the casting of palm kernels, bones, pebbles, kola nuts and small sticks of particular shape on the ground and after which the position of these elements - believed to have been placed by the ancestors - were interpreted and advice given. This device was called *sortilege*. *Augury* was used as a method of interpreting circumstances from the movement of a dying fowl hung upside down, suspended from a raffia pole and a leaf tied to the body. However, the most popular of these methods of divination throughout Bamenda population was the *ngam* method, which centred on a set of leaf-cards with standard symbols (made from the stiff flat leaves of the African plum tree known as *ntügam* (pl. *ntügam*) and the black hairy spider. During the act of divination, the spider's nest was found, a large clay pot without the bottom was covered over its entrance and the leaf cards carefully put around its hole so that, whenever it came out in search of food, it moved upon the cards. The position of each card touched by the spider was interpreted; see Paul Gebauer, *Spider Divination in Cameroon* (Milwaukee: North American Press, 1964), p. 44. )sorcerers and/or herbalists, and the keen respect of the consumption formula of the medicine obtained from them (when hide by an illness) was a general tendency in the

society. While many considered illnesses as punishment from their ancestors for some unacceptable attitudes and actions of theirs and so frequently offered sacrifices to appease them (ancestors), others believed that sicknesses were caused by their enemies through witchcraft, magic and mystery. It was for this reason that they wore protective charms. Illnesses attributed to these sources were mostly deadly diseases like smallpox, malaria, tuberculosis, measles, and meningitis (the most feared diseases). (Interview with Dr. Gunfe, 57 years, Medical Doctor of Ndu General Hospital, Ndu, 3 June 2009. ).

Due to the dissimilar geographical nature of the Anglophone area, varied diseases did exist. In the hot Forest area, illnesses like insect-borne diseases, namely malaria, sleeping sickness, filariasis and elephantiasis were very common. Such infectious diseases such as tuberculosis, ankylosmiasis, ascaris, cestoda or Guinea worm were also not uncommon. Those of the cold Bamenda Grassfields were leprosy, influenza, ulcer, rheumatism, dog bites, fungi infections, diarrhoea, cough, fever, hist, jigger and bedbugs bites, meningitis, river blindness, madness and helminthic diseases, which during the establishment of scientific medicine needed more care microscopic analysis for effective treatment. (National Archives Buea (NAB), cb/1929/1, Annual Report for Bamenda Division 1929) However, diseases common to both regions were yaws, chicken-pox, venereal, dysentery, small-pox and poliomyelitis.

When attacked by ailments, namely, ulcers, dog bites, fungi infections, diarrhoea, cough, fever, hist, jigger and bedbugs bites, chickenpox, river blindness and madness many did not worry since traditional medicine had fully understood and could check their *modus operandi* and/or *modus vivendi*. They were easily cured, and many people consequently survived them. (Interview with Samuel Ngwem, 59 years, Chief of Mbem, Mbem, 6 June 2009; interview with Dr. Charles Tebo, 55 years, Medical Doctor of Nkambe General Hospital, Nkambe, 1 June 2009). Generally speaking, the traditional doctor used roots, barks and leaves of trees for diagnosing, eliminating and preventing abnormalities in people's systems, be them physical and spiritual. When it concerned diseases like headache, dysentery, poison, compound fractures, infertility in women, and mental disorders, traditional medicine men used incantations, herbs or liquid to treat them. Healers consulted the ancestors (through the various means of divinations as earlier explained) before administering treatment. The cost of each cure varied from village to village, but ranged from being free to a goat, depending on the disease and the method to be applied during treatment. (Idem.). They also attempted treating diseases like smallpox, yaws, malaria, tuberculosis, leprosy, measles, poliomyelitis and meningitis although people attacked by them hardly survived. The dead toll was always alarming.

A number of reasons explain this high death rate. Apart from the fact that the understanding of as well as the means employed to cure these diseases by traditional healers was very approximative, most healers tried to associate a magical cause to every of these diseases, forgetting quite often the natural causes. Such attitude did not only tear families asunder and created a gulf between true friends, but caused many to seek revengeful magical action, which killed many; the victims being innocent. Most often, the deaths resulting from such actions surpassed by far those caused by the illnesses themselves. Also, some of the drugs administered did not possess a well-defined dose and thus, the incidence of over-dose was common and dangerous. When the healer was a quack or fake, the consumption of his drugs was a waste of time and only allowed the disease to degenerate into an incurable stage, causing the death of many. These notwithstanding, some persons still admitted the competence of traditional healers in treating all diseases. This did not only mislead many persons into believing them, but also to depend on them based on this mere assumption. The result of such an assumption was certainly not commensurate with action or reality and of course fatal at the end. (Interview with Martin Sindo, 82 years, traditional healer, Kungi, Kungi, 16 June 2009). Many at times due to illiteracy and the desire to get well fast, some sick persons decided to take an over-dose of what was prescribed or even neglected to continue with the treatment process immediately they felt better. The sickness only came back forcefully and resisted any further treatment. Many often took their sicknesses for granted even when they appeared serious, and would hardly seek early medical assistance only to do so when it is too late. (Idem.; D.N. Lantum, "The Pros and Cons of Traditional Medicine in Cameroon").

Nonetheless, the consciousness of seeking early medical assistance came later during the colonial period when scientific medicine and its agents penetrated the area.

## II. Scientific Medicine: Introduction and Reactionary Value

The introduction of scientific medicine into the Southern Cameroons began with the health activities of the British. Although the entire British colonial policy is beyond the scope of the paper, it is of need to mention that the British government used the policy of Indirect Rule to provide and develop health services in the area. This policy entailed that the indigenes would afford part and sometimes all of the necessary resources for the development of health services, while the colonial government guided and advised them to that effect. (Prosser Gifford, "Indirect Rule: Touchstone or Tombstone for Colonial Policy?" in Prosser and Louis (eds.), *Britain and Germany in Africa, Imperial Rivalry and Colonial Rule* (New Heaven and London: Yale University Press, 1967), p. 391.) In pursuance of this policy, the indigenes supplied some required personnel, sponsored their trainings (which were mostly done in the local hospitals), participated in the buying of medical equipment from Nigeria and the building of hospitals, dispensaries and above all, helped in the maintenance and payment of medical staff. The colonial government found excuses for the adoption of such a policy in the World Economic Crisis of 1929-1935 and the Second World War which, they claimed rendered them incapable to solely and directly provide these services in the Southern Cameroons, especially as the area during the interwar period was plagued by an incessant epidemic outbreak. ( NAB, Sca/1929/3, Hospital Fees: General

Correspondence, Ce/1932/1, Annual Report for Mamfe Division, 1932.).

Whatever, the Southern Cameroons had the Native Authorities which tried to exploit the available resources of the area to combat the diseases.

After the partition of Cameroon, the British started establishing health units in Victoria, Buea, Kumba and Mamfe (for the Forest zone) and Bamenda and Bansa (for the Grassfields area) mostly the urban centres of the four Divisions, namely Victoria, Kumba, Mamfe and Bamenda. It is in this light that in 1916, medical officers were appointed as resident doctors to the respective division as follows: Dr. F. Ross (for Victoria), Dr. C. G. Grey (for Bamenda and Dschang (Until 1917, Dschang was administered medically as part of Bamenda Division. But after 1917, it was attached to Mamfe Division.)), Dr. C. Kelsall (for Buea and Soppo), Drs. Glover, Gibson and Seiger (for Ossidinge). Kumba had no resident doctor, but Ross made intermittent medical visits there from Victoria. They were accompanied by junior medical staff (mostly foreigners) who had served with the Expeditionary forces. They included Akibayoh, Amos, Mclear, Johannes Whyfe and Manga Bell the only Cameroonian. (NAB, Sc/1916/1, Medical Stores and Supply Correspondence, 1916.) It is possible that the military administration took this arbitrary decision in order to cater for the health of the military personnel and the civil servants who were dotted throughout the divisional headquarters called "Stations". ("Stations" were the quarters wherein Europeans and African administrators lived, different from the native population. Although the Europeans and Africans lived in these "Stations", the former had separate quarters, mostly where the administrative offices were located. This distinction was clear to and respected by all.). Sometimes medical services in these early years were extended to the native population whenever it was suspected that they were sources of infection that threatened the health of the station. This explains why early medical reports of the territory talks of the "health of the European and the African civil servants before all else". If any epidemic originated from the African quarters these documents made mention of how the doctors dealt with it. Their success in dealing with the ailments was determined by three important variables, namely, how well was the health units organised, the availability of medical supplies, the prompt payment and arrival of the drugs from Nigeria. A division by division survey of the establishment and expansion of the health services shows how the indigenes benefited from and/or reacted to the presence of scientific medicine in Southern Cameroons.

## Victoria and Buea Health Units

The British colonial authorities in introducing and establishing scientific medicines in Victoria and Buea, like elsewhere in Southern Cameroons, needed buildings to host the medical centres. The German buildings were found most suitable for the purpose until 1927 when semi-permanent buildings or local type of houses were constructed to host patients. In Victoria, an old German building used as a hospital was becoming inadequate by the end of 1916, but it was only in 1930 that a Victoria German garden house was transformed into a European hospital so the first could be reserve for the Africans. By 1928, the one-ward-African hospital was serving a population of 36,724 Africans while the European hospital catered for 235 Europeans. (NAB, Sca/1928/1, Annual Report, 1928.)

Why the African hospital became congested was obvious. It served both the plantation labourers (who had had an earlier, but ingested experience with scientific medicine during the German colonial administration) and the entire indigenous population, which was being plagued by the small-pox, yaws, chicken-pox, dysentery and influenza epidemics. The annual reports of 1917-32 record that the increasing response of the Africans to scientific medicine was propelled in the main by the devastating nature of these ailments on the populations and the people's inert desire to stay safe from death, yet the hospitals were understaffed to satisfy this yearning. In 1929, therefore, the administration tried to reduce the problem of overcrowding in the hospital by allocating 350 pounds (sterling) for the construction of two semi-permanent buildings for the Africans. Consequently, the African hospital expanded with 3 main block of 2 male, 1 female and 1 children wards. The European hospital had a nursing sister assisting the doctor, and before the end of the mandate period, it had been enlarged to accommodate 8 beds and could adequately serve the few foreigners who were not all residing around Victoria (NAB, Cf/1929/1, Annual Report for Victoria Division, 1929.)

In Buea, an old German bungalow was transformed into a hospital in 1917 with a resident doctor until 1933 when he was withdrawn to join the Tse-tse fly Investigation Team in Tiko. This left the four-bed-and-one-isolation ward hospital in the hands of a Grade one nurse and two servants with the Victoria-based doctor as a visiting medical officer. More so, in 1946, the Custodian of Enemy Property (the government agency charged with liquidating German property in the Cameroons at the end of the Second World War), opened the Plantation hospitals at Tiko and Likumba to the public. Hence, before the end of the Mandate period, five hospitals existed in Victoria Division with four opened to Africans, all supervised by the colonial government. (Ba/1943/1, Annual Report Cameroons Province, 1943.) These health establishments and personnel made use of the available medicine to feed the patients who often reacted differently to the treatment.

Since a handful of the local population of the Victoria Division had been familiar with European medicine since the German era, their response to scientific medicine was impressive. In fact, hospital attendance during the mandate period was high, mainly because of the series of epidemics which broke out during the period and the inability of traditional healers to handle the diseases (as earlier highlighted). Table 1 indicates the response attitude of the inhabitants of the area to medical care during a four-year period of 1930-34.

**Table 1.** Victoria and Buea Hospitals Situation

Victoria African Hospital					Buea Hospital			
Year	I.P.	O.P.	Operation	Deaths	I.P.	O.P.	Operation	Deaths
1930	730	3.359	201	-	327	671	80	-
1932	1.352	6.629	214	75	200	2.992	154	-
1933	782	6.852	-	75	151	5.769	115	16
1935	905	11.871	533	63	70	6.000	152	20

Source: NAB, cf/1930/1, cf/1932/1, cf/1933/1, cf/1935/1 Annual Reports Victoria Division, 1930, 1932, 1933, 1935.

Note: I.P. = In patients and O.P. = Out patients. With the European hospital, no death or operation occurred and the I.P. stood at 27, 8, 21 and 14, and O.P. was 59, 51, 85 and 63 for the respective years. The dashes on the table, like any other in the paper, indicate the unavailability of data for the years provided.

From the table the drop of attendance in Buea hospital from 1932 for in patients was due to the fact that the presence of resident doctor was becoming unstable. Thus, each time he resumed work it took the population time to regain confidence in the hospital treatment. The permanent withdrawal of the doctor at the end of 1933 killed the desire for hospital treatment in the locals, who tilted their interest to the Victoria hospital or resumed their traditional consultations and treatment. (NAB, Se/1933/1, Sleeping Sickness and Tse-tse fly Investigation, 1933.) This declining response of Africans to scientific medicine often occurred when they were unsatisfied with the services the hospital provided or when the hospital fees became too high for them to pay. For example, in 1924 when William Arnet, the Resident for the Cameroons Province, introduced fees in the Victoria African hospital, the locals chose to go to Douala where French hospitals treated them almost free; accepting their payments in cash or in kind. (Ibid.)

The diseases common amongst the patients of the division were venereal, elephantine, yaws, small-pox, chicken-pox, bronchitis, tuberculosis and filarial. In 1928, 75 percent of the cured patients suffered either from ankylostomiasis, ascariasis, cestoda or Guinea worm. In Kumba particularly, the yaws, malaria, leprosy and tuberculosis ailments were reportedly more rampant. Dr. C.E. Chantler in 1930 reported many cases of malnutrition, caused by the lack of proteins as the staple diet of the area was plantains and cocoyams. (Cd/1930/1, Annual Report for Kumba Division.) Of course, although Kumba was the heart of the forest zone where hunting and fishing exercises provided the people with some amount of proteins, the quantities caught were usually not sufficient. This was aggravated by the existence of trypanosomiasis that hindered the rearing of cattle in this forest area. In fact, beef could have biffed up the protein supply.

### Kumba Hospital Attendance

Although the local population of Kumba was slow at turning to scientific treatment, the response was increasing steadily from 1927 when the resident doctor, Dr. Chantler, was appointed to the hospital, and he made periodic tours to the villages to encourage the people in embracing scientific medicine. This steady response attitude is reflected on table 2.

**Table 2.** Africans Response to Scientific Medicine in Kumba

Year	In Patients	Out Patients	Operations	General Attendance
1927	214	5.408	-	14.170
1928	302	5.758	-	11.659
1929	317	10.723	168	-
1930	835	6.149	719	-

Source: NAB, Cd/1924/1, Cd/1928/1, Cd/1929/1, Cd/1930/1, Cd/1924/1, Annual Reports, Kumba Division, 1927 to 1930.

When a new hospital was opened in 1929, the treatment of outpatients rose, but dropped sharply the following year since the yaws and small-pox epidemics which hit the other divisions were not severe in Kumba. Besides, six junior medical staff were trained (led by J.A. Etie) and they serve in the different Native Authority Areas of the division.

### Mamfe Medical Services

By 1917, the population of Mamfe was already benefiting from the presence of scientific medicine. This was facilitated by the intermittent medical visits of the resident doctor of Victoria. He extended these visits to Dschang since it constituted part of Mamfe medical area. But due to the enclave nature of the area and his desire to serve a greater portion of the sick population, he initiated wayside clinics on the roads to Kumba, Bamenda and other thickly populated villages of Mamfe, namely Mamfe-Kembong (with stops at Nchang, Ossing and Mfuni), Mamfe-Tali (with three clinics) and Mamfe-Widekum (with five clinics). (NAB, Ce/1938/1, Mamfe Annual and League of Nations Report, 1938.) The villagers, whose growing interest in modern medicine was sustained by the news of the doctor's efficiency, drugs and

encouraging words, mastered his visiting days. On such days, patients from villages far off the main roads came to consult with him.

The cooperation atmosphere that existed around the wayside clinics was worthy of note. More often villagers alone the road housed the sick persons from far off villages, offering them not only the possibility to consult first, but also provided them with food. Sometimes they offered to carry serious sick cases to the hospital at Victoria or Bamenda at the request of the doctor. The confidence both the people and the doctor had in each other sustained the people's interest in scientific medicines. In fact, the local population soon developed the habit of inviting the doctor whenever there was an epidemic outbreak. In Tali in 1930 with the outbreak of the yaws epidemic, and when it was not yet their turn for the doctor's monthly medical tour the doctor promptly intervened following the invitation of the Chief. The people's interest in European medicine became noticeable by the colonial authorities who granted them a hospital in the late 1931, and terming the people "the most remarkable lovers of medicine in Southern Cameroons." (NAB Ce/1930/1, Annual Report for Mamfe Division, 1930.) The creation of a new hospital increased the peoples desire to consume the whiteman's drugs. The Annual Reports for Mamfe Division states that the hospital attendance rate increased in "geometrical progression," (Ce/1938/1; Ce/1938/1.) see table 3.

Apart from the aforementioned reasons, the possible explanation for the rapid increase in both the out and in patient attendance from 1925-34 could also be attributed to the venereal diseases, dysentery, chicken-pox, yellow fever and filariasis ailments which persisted throughout in the area. The hospital treated these diseases effectively and quickly. This effect led to the increase from a 21 bed hospital in 1931 to 70 in 1934. With this increase, it was obvious that more medical staff would be needed. It was in meeting this need that the doctor trained more traveling dressers and dispensers to serve the hospital and its environs. The story was not so different in the Grassfields region, particularly in Bamenda and Bansa hospitals.

**Table 3. Hospital Attendance and Treatment: Mamfe Division**

Year	In Patients	Out Patients	Operations	General Attendance
1925	101	4.216	-	-
1926	232	4.320	-	-
1930	614	3.662	312	32.249
1933	771	7.177	330	32.703
1934	959	10.246	588	52.260

Source: NAB, Ce/1934/1, Annual Report for Mamfe Division.

### **Bamenda and Bansa Health Services**

Dr. C.G. Grey arrived in Bamenda in 1916 when there was a yellow fever epidemic. The temporary hospital (relic of German colonial era) which he met had a 19-bed inpatient ward and a 10-bed isolation section (to house yellow fever patients). Until 1928 when the Common Plan Hospital was completed, the temporary hospital was always full and under constant repairs by the District Officer for the division. Even the new hospital became inadequate by 1932 and the Native Authority had to vote the sum of 400 pounds (sterling) for the expansion of the isolation section to 27 beds. (NAB, Cb/1932/2, Annual Report Bamenda Division, 1932.) The World Economic Crisis of 1929-35 slowed down the expansion of the hospital. However, by 1936 the hospital was completed. With improved medical equipments Grey ordered from Nigeria, the new hospital did not only treat the common diseases of the area, but also undertook complicated surgical operations.

But in most cases the pathological conditions of the patients and the advance stages of their cases made the operations a little more difficult. The doctor carried out at least five operations daily, and due to the lack of sophisticated surgical instruments, the District Officer for Bamenda reported that there were very septic cases arising from the operation. Nevertheless, people generally continued to gain increasing confidence in the effectiveness of modern medicine and responded to it (as shown on table 4), especially as the result of the outbreak of the small-pox, influenza, yaws and meningitis epidemics was devastating on the population between 1924 and 1944. Medical reports record that this was the worst period in the Southern Cameroons as both the local and the European administrators, namely, N.C. Duncan, G.B. William and A.E. Tweed (officers for Bamenda Division), B.E.S. Smith (Mamfe), and C.S. Hesketh and C.S. Ure (of West African Frontier Force) were exceedingly attacked. In fact, the small-pox and yaws epidemics broke out simultaneously in Bafut, Bansa and Kom, hence keeping the general population awake to scientific medicine. This as well prompted them to respond increasingly to the vaccination exercises organized by the hospital, the reason why by 1945 over 18,000 persons had been vaccinated against small-pox, yaws and influenza. (NAB, Cb/1946/1 Annual Reports Bamenda Division, 1946.)



**Table 4.** Response to Scientific Medicine in Bamenda 1924-44.

Year	In Patients	Out Patients	Operations	General Attendance
1924	472	5.006	72	-
1925	493	5.009	-	-
1926	789	5.726	-	-
1943	1.296	12.887	436	25.260
1944	1.230	10.022	551	39.351

Source: NAB, Cb/1944/1 Annual Reports Bamenda Division, 1944.

Note: the hospital served people from Wum as well.

It was the effect of these epidemics amidst poor communication network and the size of the division that caused medical establishments to be expanded in the rural settings of the area, like Bansa (sixty-five mile from Bamenda). It was in the rural areas that chiefs and missionaries worked hand in hand to combat the epidemics and other common diseases like taenia and lumbriocide (found in cattle rearing areas of Mbem, Lus, and Mfunte), syphilis and gonorrhea. Whatever, in 1925, the British administrators opened in Bansa a hospital. The temporary hospital built from funds jointly provided by the government and the Native Authority and constructed by E.G. Hawkesworth (the District Officer for Bamenda), served the entire area including Nkambe- Kaka and Nsungli areas). Consisting of a ward, a central block of three rooms for the dispensary, a consultation room, an office and apartments for the doctor (Dr. James), dispenser and nurses, the hospital became very popular due to three main reasons: First Dr. James opened a venereal disease clinic therein and introduced a team of sanitary workers to parade the village. Second, all the traditional rulers campaigned in favour of modern medicine by constantly visiting the hospital themselves. They also commissioned their soldiers to carry every serious patient to the hospital. Third, Baptist, Catholic and Basel missionary nurses had started mobile medical work in this area of the Cameroons and often referred their very sick persons to the hospital (table 5 shows the attendance statistics of 1923-50). (Mark Bolak Funteh, "Cameroon Baptist Convention Conflicts 1954-2002: A Historical Investigation," Ph.D. Thesis in History, University of Yaounde I, 2009, pp. 415-416) It was the admiration for how the hospital served the area and the commitment of its missionaries to the effectiveness of the hospital that prompted the Baptist Mission to purchase the hospital from the colonial administrations when approached in 1948 to do so. They named it the Bansa Baptist Hospital. The hospital remains one of the reference hospitals in Cameroon today in terms of equipment and services (Ibid.) (see plate which shows the hospital by 2005).

**Table 5.** Bansa Hospital Attendance

Year	In Patients	Out Patients	Operations	General Attendance
1933	95	2.375	-	9.375
1945	227	2.546	70	11.418
1950	616	4.185	105	11.525

**Source:** Mark Bolak Funteh, "Cameroon Baptist Convention Conflicts 1954-2002: A Historical Investigation," Ph.D. Thesis in History, University of Yaounde I, 2009, p. 420.

**Figure2.** Bansa Baptist Hospital

Source: snapped by Mark Bolak Funteh, 2005.



It is worthwhile noting that the official acceptance of missionary nurses in the health care in Southern Cameroons did not exist before 1929. Prior to this time, the government did not approve of missionary nurses to practise medicine. They needed permission from the government before dispensing drugs (Poison and Pharmacy Ordinance) without which such actions were termed illegal. This was because the government doubted the efficiency of missionary personnel in the health domain, thus the early missionary health services which existed were unrecognised by the government and were limited to the treatment of minor ailments of their converts.(NAB, Sca/1934/1, Grants to Medical Missions, 1934. ) But from 1929, the situation was different. The Permanent Mandates Commission of the League of Nations recommended Mandate powers to accelerate the development of the health services of their respective territories, to legalise the work of private doctors, and to give subventions to missions in opening up hospitals. The consistent outbreak of epidemics, the enclave nature of the area and the Commission's recommendations prompted the British colonial government to give the missions the latitude to open and run hospitals, mostly in the rural areas where the need for good health was alarming. Thus the Baptist opened up more dispensaries hospital, namely the, Mbem Baptist Dispensary in 1936 (that served the Yamba, Mbaw and Mfumte areas, and administered treatment to over 9.000 persons by 1948), the government subsidised Baptist dispensary in Buea in 1939 (which served Soppo, Bimbina, and Moliwe suburbs, and administering treatment to over 7.800 persons by 1938) and New Hope Settlement (N.H.S.) – Leprosy Centre – at Mbingo in 1952. (in 1954 it was officially opened as the Mbingo Baptist Hospital to serve the entire Kom area).( Funteh, "Conflicts," p. 411.)

In Victoria, the Basel Missions began running a dispensary in 1932, and by 1936, it was effectively working among the women through trained nurses. Like with the other mission dispensaries where they trained their nurses, these nurses made home visitations or organise mid-week training sessions to discuss about health related issues. It was during such sessions that mid-wives were trained. In Victoria by 1938, for example, the Basel mission treated over 4.800 cases of women and children related diseases and registered close to 550 serve deliveries. The advent of these mission health units, reinforced the Native Authority dispensaries opened in most parts of the Bamenda Division before 1945 (Bamunka in 1932, Batibo in 1933, Bali in 1942 and Bafut in 1944) to fight against the epidemics and other illnesses plaguing the area.(Ibid., p. 479; NAB, Cb/1944/1, Annual Report for Bamenda Division, 1944. These dispensaries like the mission establishments were authorised to vaccinate as well as give Sobita injections and emitine during the small-pox and yaws epidemics. The Native authorities opened these units in relatively populous areas to serve the remote areas rural population as well as to raise revenue with which drugs could be bought since the government had stopped the supply of free drugs to all Native Authorities in the territory.)Table six shows statistics of patients who attended Native Authority dispensaries. As a matter of fact, these health establishments did not operate hitch free, rather faced a series of difficulties in their processes of establishing good health in the territory.

**Table 6.** African Response to Modern Medicine in Native Authority Dispensaries, Bamenda

Dispensary	1935		1942		1944	
	Treatment	Attendance	Treatment	Attendance	Treatment	Attendance
Bamunka	2.554	16.428	4.400	14.013	4.905	13.762
Batibo	4.271	12.373	2.875	4.953	3.118	4.475
Bali	-	-	3.549	5.590	2.667	12.963
Bafut	-	-	-	-	2.760	9.894

Source: NAB, Cb/1944/1, Annual Report for Bamenda Division, 1944.

Note: Generally, the administration, in getting the rural population interested in scientific medicine, amongst other methods, utilise the chiefs and some influential notables in the territory. This indirect method of dealing with the people was particularly functional in Bamenda Division where the people had strong and organised centralised independent fondoms. For instance, in Bali, Bamunka and Bambui, almost everybody turned up for vaccination campaigns organised in the 1935 merely because their chiefs were vaccinated.

Amongst the many of these constraints are the following: The area of Southern Cameroons was so large and enclave for the few medical personnel to cover effectively; availability and viability of well-trained medical personnel to tackle the varying but consistent epidemics that plagued the area was greatly lacking; the supply of needed equipment and drugs from Nigeria was never enough (sometimes in the rural settings drugs were consumed by healthy persons for the sake of testing the scientific medicine consequently wasting the drugs) and most at times drugs took long to arrive the region; and the people's great value to and attachment with traditional medicine did not work well for the advancement of scientific medicine at times in all places. In fact, this is still one of the greatest obstacles to the advancement of scientific medicines in most parts of Cameroon, especially in the rural settings.

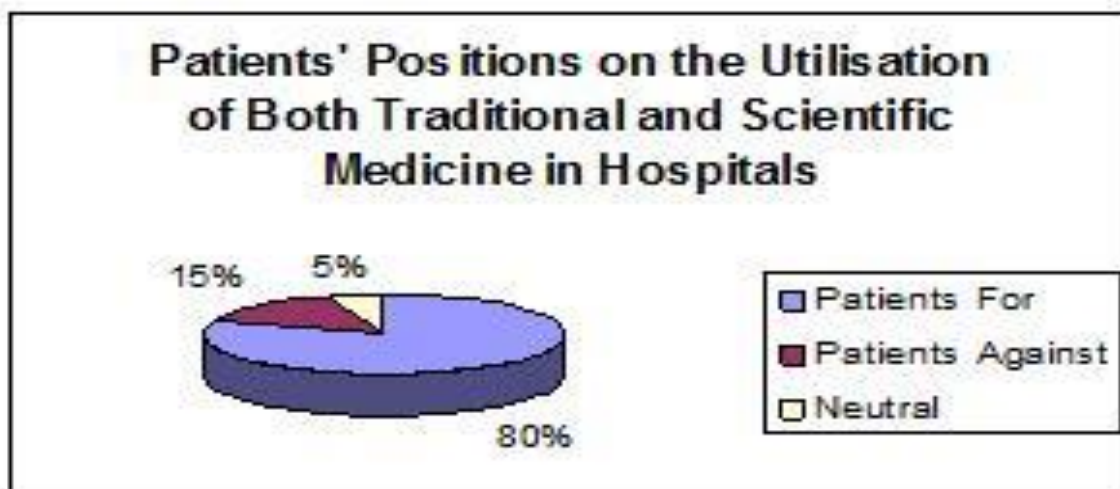
During interviews conducted to understand why many Cameroonians still strongly prefer traditional to modern medicine, these reasons were specified. The health establishments are few and nonexistent in some rural settings. Consequently patients' hopes lie with traditional practitioners; diseases like yellow fever, madness, epilepsy and so on has so far been able to be treated by traditional medicine; the poor who cannot afford to pay for drugs in the pharmacies or in the hospitals prefer traditional healers. Some of these healers do not even ask for money or any other kind of payment. Generally traditional healers are less demanding than modern doctors.(Interview Dr. Gunfe; interview with Chief Ngwem.)

The traditional healers understand fully the socio-cultural problems of the area in question, and use this knowledge in diagnosing the patients' illness. They are very close to thinking of the people they deal with, for instance , if a patient

complains that he has been beaten by spirits at night, the traditional healer will understand him better and help to drive away the evil spirit, and hence blindly considered efficient and accepted by most in these remote areas. Most of the healers and patients hail from the same tribe, and in such a case, there is contact without any complex, and during the treatment patients are freely lodged and fed which is not obvious with modern medicine. (Interview with Chief Ngwem.)

The traditional healers use very simple instruments when treating their patients, for example, horns of animals, calabash, hoe, sticks, which the people are familiar with, and not strange and frightening apparatuses like injection, X-ray machines and so on. With traditional medicine, there are no such lengthy procedures as having to examine the eyes, urine, pulse and so on before administering drugs. Traditional healers give protective charms and talismans, and since most of the masses are illiterates and believe in witchcraft, magic and mystery they have trust in wearing these charms. The lack of sufficient health education on particular illnesses makes the masses believe strongly in traditional medicine as healers do trace the causes to the time of ancestors to clarify a doubtful past and foretell the future. Unlike modern doctors with their field of specialisation, most traditional healers are versed in the treatment of wide range of diseases. In this way, the patient firmly believes the healer's capacity as a true doctor. The traditional healers treat the diseases and the individual as a whole; they follow the patient's family and their total environment and give drugs in bulk so that the patients can continue to use them in future, also, most of the diagnoses are automatic. (Interview with Dr. Gunfe; see Lantum, "Pros and Cons," pp. 87-90. )

More so, the treatment of certain diseases is instantaneous and automatic, and for consultation little time is lost unlike in the hospital where patients have to stand in lines. Prescriptions are simple with no surgical operations. Generally, there exist some beliefs that traditional medicine must be better and more efficient since traditional medicine preceded modern medicine. (Lantum, "Pros and Cons," pp. 87-90.) However, many people opine that if modern and traditional medicines can corporate in the healing processes of patients, many complex ailments can effectively be eradicated. The diagram below indicates the position of patients (in a random interview conducted in Banso Baptist, Bamenda and Buea General Hospitals) in relations to the combination of both traditional and modern medicine in treating diseases.



**Figure 3:** Patients Position on the utilisation of both traditional and scientific medicine in hospitals

## CONCLUSION

The forgoing analysis argues that the British Government played a vital role in the introduction and process of advancing scientific medicine in Southern Cameroons, a complex traditional society where traditional methods of health were practiced. The Germans had earlier used modern medicine, mostly in the coast, but not on the local population. But from 1916 with the results of the First World War, the division of Cameroon and the League of Nations' Mandate expectations, Britain effectively used the colonial government, Native Authorities and missionaries of the mainstream Christian denominations to penetrate the region into the hinterlands with modern form of medicine. While the former focused in establishing hospitals in the urban settings, the latter two handled health services through dispensaries in the rural areas. The advent of scientific medicine to the area coincided with the chain of epidemics outbreak that plagued the population and recorded devastating results. The utilisation of the few personnel, medical equipment and drugs throughout this vast territory was not an easy task. However, the relative success they obtained relied upon the various strategies used, which included the utilisation of some local traditional authorities. The interest and response of the local population steadily grew as time passed by, even though many still opted and sustained their likeness towards traditional means of obtaining good health despite the presence of hospitals and dispensaries. To some, traditional and scientific medicine can blend together in order to obtain the best results, each complementing the other. In fact, traditional medicine, as the oldest form of health care in the world, used in the prevention, and treatment of physical and mental illnesses in different societies is also variously known as complementary and alternative, or ethnic medicine, and

it still plays a key role in many countries today. The medicaments used in Traditional medicine are mostly derived from natural products. In traditional medicine, “clinical trials” have been conducted since ancient times. In this case, considerable experience and advances have been accumulated and developed over the past thousands of years with respect to methods of preparation, selection of herbs, identification of medicinal materials, and the best time for obtaining various different plants. Appropriate processing and dose regulation are urgently needed traditional medicine to improve drug efficacy and reduce drug toxicity. Considerable amounts of data have been acquired through clinical experiments, and in this way this medicine type has assisted in the development of modern drugs.

Through its use of natural products, traditional medicine offers merits over other forms of medicine in such areas as the following: discovery of lead compounds and drug candidates; examining drug-like activity; and exploring physicochemical, biochemical, pharmacokinetic, and toxicological characteristics. If any form of traditional medicine is applied successfully, it may surprisingly assist in the development of new drugs, thereby resulting in many benefits, such as significant cost reductions. It is now an inseparable part of most countries like Chinese, Japan and Chad public health system. In recent years, traditional medicine has gradually gained considerable approval as a complementary or alternative medicine. Even in Western countries. Chinese herbal medicine, which is the most important component of traditional medicine, is currently used in the health care of an estimated 1.5 billion people worldwide. It should be noted that in traditional medicine, several herbs and ingredients are combined according to strict rules to form prescriptions, which are referred to as formulas (*fang ji* in Chinese). Commonly, a classic formula is composed of four elements—the “monarch”, “minister”, “assistant”, and “servant”—according to their different roles in the formula, each of which consists of one to several drugs. Ideally, these drugs constitute an organic group to produce the desired therapeutic effect and reduce adverse reactions. The colonial health units in the Cameroons did not totally ignore traditional medicine.

It was upon the efforts and experiences of the colonial hospitals and dispensaries that the Government of Cameroon relied on to advance medical care in the area after 1961, as many more hospitals and mission health centres and organisations (ONAREST) were created and/or encouraged to operate. In fact, with the growing population and the inescapable health challenges of Africa, their desire to meet up with the millennium goals by the Africans in general and Cameroon government in particular can only be effective if both traditional and modern medicine given due recognition, place and attention as complementary entities often encouraged by the World Health Organisation.

## REFERENCES

### a. Books, Articles and Dissertations

- Ebune, Joseph B. *The Growth Political Parties in Southern Cameroons 1916-1960*. N.p.: 1992.
- Fabricant, D.S.; Farnsworth, N.R. “The Value of Plants Used in Traditional Medicine for Drug Discovery” *Environ. Health Perspect.* 109, 2001:109, 69–75.
- Fanso, Verkijika G. “Anglophone and Francophone Nationalism in Cameroon” in *The Commonwealth Journal of International Affairs*. 350, 1999: 282.
- Funteh, Mark Bolak. “Cameroon Baptist Convention Conflicts 1954-2002: A Historical Investigation.” Ph.D. Thesis in History. University of Yaounde I, 2009.pp. 415-416.
- Gebauer, Paul. *Spider Divination in Cameroon*. Milwaukee: North American Press, 1964.
- Gifford, Prosser. “Indirect Rule: Touchstone or Tombstone for Colonial Policy?” in Prosser and Louis (eds.), *Britain and Germany in Africa, Imperial Rivalry and Colonial Rule*. New Heaven and London: Yale University Press, 1967.
- Joh, Ernest. *Traditional Medicine in Kom*. Bamenda: Unique Printers, 2006.
- Lantum, D.N. “The Pros and Cons of Traditional Medicine in Cameroon”.
- Llyod, Daniels. *The Scores of Scientific Medicine in Africa*. Nairobi: Eliot Publishers, 2008.
- Rudin, H. R. *Germans in the Cameroon, 1884-1914: A Case Study in Modern Imperialism*. New Haven: Yale University Press, 1969.
- Shi, Q.W.; Li, L.G.; Huo, C.H.; Zhang, M.L.; Wang, Y.F. “Study on natural medicinal chemistry and new drug development” *Chin. Tradit. Herb. Drug.* 41, 2010: 1583–1589.
- Shirley, Ardener. *‘Eye-Witnesses to the Annexation of Cameroon’*. Buea: n.p., 1988.
- Sindo, Abraham. *Local Healers among the Ndop of Cameroon*. Buea: n.p., 2003.
- Sir Reginald, Coupland. *‘Welsh and Scottish Nationalism-A Study’*. London: n.p., 1954.

### b. Archival Material (National Archives Buea)

- Sc/1916/1, Medical Stores and Supply Correspondence, 1916.
- Sca/1928/1, Annual Report, 1928.
- Cb/1929/1, Annual Report for Bamenda Division 1929.
- Cf/1929/1, Annual Report for Victoria Division, 1929.
- Cd/1930/1, Annual Report for Kumba Division.
- Ce/1930/1, Annual Report for Mamfe Division, 1930.
- Sca/1929/3, Hospital Fees: General Correspondence, Ce/1932/1, Annual Report for Mamfe Division, 1932.
- Cb/1932/2, Annual Report Bamenda Division, 1932.
- Se/1933/1, Sleeping Sickness and Tse-tse fly Investigation, 1933.
- Sca/1934/1, Grants to Medical Missions, 1934.

Ce/1938/1, Mamfe Annual and League of Nations Report, 1938.

Ba/1943/1, Annual Report Cameroons Province, 1943.

Cb/1944/1, Annual Report for Bamenda Division, 1944.

Cb/1946/1 Annual Reports Bamenda Division, 1946.

**c. Interviews**

Dr. Gunfe. 57 years. Medical Doctor of Ndu General Hospital. Ndu. 3 June 2009.

Dr. Charles Tebo. 55 years. Medical Doctor of Nkambe General Hospital. Nkambe. 1 June 2009.

Samuel Ngwem. 59 years. Chief of Mbem. Mbem. 6 June 2009.

Martin Sindo. 82 years. Traditional healer. Kungi. 16 June 2009.