

Traditional Medicine, Disease Control and Human Welfare in Colonial Southern Cameroons

Christian Asongwe*

Department of History Faculty of Arts University of Bamenda

DOI: [10.36348/sjhss.2021.v06i01.005](https://doi.org/10.36348/sjhss.2021.v06i01.005)

| Received: 16.01.2021 | Accepted: 25.01.2021 | Published: 30.01.2021

*Corresponding author: Christian Asongwe

Abstract

This paper examines the continuing relevance of the traditional healthcare system as a disease control mechanism in colonial Southern Cameroons. Prior to the introduction of western medicine, there existed an effective traditional medical system that constituted the basis of healthcare delivery. The coming of biomedicine in a context of European colonialism opened the way for a consistent attack on indigenous healthcare practices. In most parts of Southern Cameroons, medical facilities were developed with the intent of making preventive and curative healthcare available to the local population. Surprisingly, a cross section of the indigenous population kept their trust on traditional medicine, thus permitting it to survive colonial attacks. Throughout the colonial era, traditional doctors concocted various medicinal plants and incanted spiritual forces against such dreaded diseases like typhoid, malaria, scabies, dysentery, witchcraft and other diseases whose prevalence had a negative bearing on people's welfare. This paper explores why and how traditional medicine remained important in the lives of Southern Cameroonians despite the promotion of Western biomedicine. It builds on primary and secondary data to demonstrate that traditional medicine helped in reducing the prevalence of diseases and encouraged socio-economic development, with a resultant imprint on the livelihood of the local population. In fact, the resultant treatment of some of these diseases was beneficial to the health of the population and facilitated in many ways the social and economic development of colonial Southern Cameroons.

Keywords: Southern Cameroons, colonialism, biomedicine, traditional medicine, disease control.

Copyright © 2021 The Author(s): This is an open-access article distributed under the terms of the Creative Commons Attribution 4.0 International License (CC BY-NC 4.0) which permits unrestricted use, distribution, and reproduction in any medium for non-commercial use provided the original author and source are credited.

INTRODUCTION

In societies across the world, people have always been confronted with numerous diseases that negatively affect their health and general welfare. Expectedly, surmounting these diseases and improving on health has always preoccupied societies throughout human history. This explains why man's history is replete with various efforts aimed at promoting health. Such efforts as Ruth Prince observes were focused on specific healthcare needs, treatment of diseases, support service provision, combine research with provision of healthcare among other things [1].

In African societies health and healing were at the heart of socio-moral, political and cosmological order before the encounter with colonialism. Overall, most traditional African cultures believed that to maintain the health and vitality of human beings they had to address forces in both the natural and spiritual worlds. This explains why there existed a traditional healthcare system in communities across the continent. The healing art in African communities, as Ndenecho observes, consisted of two major elements that were often used in combination: the application of natural products and an appeal to spiritual forces. Regarding natural products, they consisted of extracts from leaves, roots, oils, fats, animals' parts or insects. The appeal to spiritual forces involved incantations, symbols and sacrifices among other ritual observances. This traditional healthcare system flourished well in pre-colonial Africa in general and Southern Cameroons in particular before the imposition of colonialism. But like in other parts of the world, Africa faced numerous health challenges especially the prevalence of diseases

¹Ruth J. Prince, "Situating Health and the Public in Africa: Historical and Anthropological Perspectives", In Ruth J. Prince & Rebecca Marsland, editors, *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives*, Athens, Ohio University Press, p. 10.

like malaria, sleeping sickness, chicken-pox, leprosy, small pox among others. Hence, though effective, the traditional healthcare system in pre-colonial Cameroon societies lacked the capacity to meet some of the health needs of the people.

The imposition of European colonialism led to the introduction of biomedicine which began competing with indigenous medicine. In Southern Cameroons, the introduction of Western medicine was begun by English missionaries in the 1840s and its propagation became intensified during the successive eras of German and British colonialism. Europeans presented Western biomedicine in Africa as a benevolent European gift to a people whose understanding of healthcare had been bedevilled by primitive superstition, witchcraft and ineffectiveness [2]. Placed under such academically untenable context of generously improving the health of local populations and dragging the people out of primitiveness by civilizing them, Western scientific principles of biomedicine began to take shape in such a context that was foreign to it. There was this belief among Europeans that the principles of their medical practice had a universal status, with a potential to be applied to equal effect across all societies and peoples. No wonder they denounced the people's traditional medical and began introducing the Western type without any slightest effort to associate both systems for better results. Hence, this Western medicine's trek to Southern Cameroons and Africa at large was built on the false premise that African medicine was primitive, ineffective and caged in a long history of under civilization. Surprisingly Africans had relied on this healthcare system for good health and for their social and economic advancement given that they saw healthcare as inextricably linked to societal advancement. This probably explains why many indigenous people continuously relied on traditional medicine despite the presence of Western medicine in its preventive and curative forms.

In light of the foregoing, this paper explores why and how traditional medicine remained important in the lives of people across Southern Cameroons despite the presence of Western-styled medical facilities, doctors, nurses, and midwives. The two opening sections of the paper present traditional medicine in pre-colonial Southern Cameroons in view of appreciating why it survived colonial assaults. In the third section, the development of Western medicine in the territory is discussed. This is followed by an analysis of colonially-inspired prejudices and attacks against traditional medicine. The final section of the paper examines the continuing importance of traditional medicine in colonial Southern Cameroons, with much

² Marynez Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, Cambridge, Cambridge University Press, 1992, p. 76.

focus on how some diseases were battled by traditional doctors in communities across the territory.

Traditional Healthcare Practices before the Introduction of Western Biomedicine

In pre-colonial Southern Cameroons, like elsewhere in Africa, the people suffered from many diseases. The most serious diseases that existed and greatly affected the population were malaria, small pox, sleeping sickness, dysentery, black-water-fever, various venereal diseases and leprosy. There existed other ailments like tuberculosis, many skin diseases, pneumonia, beri-beri filariasis, tumours and so many worm diseases. Generally, the diseases could be categorized under transmissible infections, hereditary diseases, those relating to the human mind, the nervous system, blood related diseases, the circulatory system, the respiratory system, the digestive system, the excretory system, the skin and the reproductive system. These diseases were common in Pre-colonial Southern Cameroons prior to the colonial encounter as confirmed by Harry Rudin [³].

The various people of Pre-colonial Southern Cameroons developed a traditional health care system intended to surmount these illnesses. The healing act of these people which varied from one ethnic group to the other consisted of two major elements which were often used in combination. They included the application of natural products and an appeal to spiritual forces [⁴]. With regards to natural products that came from the forest and savannah vegetation, they comprised extracts from leaves, roots, oils, fats, and animal parts or insects. As concerns the appeal to spiritual forces this was done through incantations, symbols, and sacrifices amongst other rituals. This traditional health care practices despite variations were common amongst the Tikars, the Widikum, the Wimbun, the Chambers, the Bakweri, the Banyang, the Ejagham and the Bakossi [⁵]. This traditional health care system was the preserve of traditional medical practitioners. The behaviour of these traditional practitioners and the population as a whole towards each of the above mentioned diseases depended on their socio-cultural environment. In short, all these illnesses were experienced and shaped by the patients' socio-cultural influences. In cultures across the area under study, diseases were cultural and constituted socially learned responses to symptoms that included the way we perceive, think about, express and come with sickness. Hence, they were cultural beliefs associated with every illness. It is important to

³H, Rudin, *Germans in the Cameroons 1884-1914: A Case study of modern Imperialism*, New York, Greenwood Press Publisher, 1968

⁴Emmanuel Neba Ndenecho, "Traditional Health Care System and Challenges in Developing Ethnopharmacology in Africa: Example of Oku, Cameroon", *Ethno Med*, Vol. 5, No. 2, 2011, p. 133.

⁵ Ibid

understand these socio-cultural beliefs of the people of Pre-colonial Southern Cameroons and how they affected health care seeking behaviour as a means of appreciating the methods and obstacles of British health services in the area.

These people had a complex system of health care known as traditional medicine which was borne out of their experience, culture, and belief system and disease environment. The ideology of this health care system was that the treatment of patients was limited to physical therapy but was interconnected with the health of the body, mind and spirit. Traditional doctors treated a variety of diseases and afflictions. These traditional doctors were generally categorised into two types; those who relied on herbal remedies and others who were 'spiritualists' and evoked spirits in the preparation of medication or treatment of patients. The latter were diviners, believed to be the link between humans and the ancestors [6]. In most cases, both methods were combined. With the skills acquired, they were able to maintain a system of healthcare until the arrival of the Europeans and continued under colonial rule to provide alternative medicine. The importance of this health care system was its emphasis on primary health care approach which endorses the full liberty of the nation, individuals or collectivities to depart from conventional approaches, as much as possible, in seeking new ways of promoting and developing their healthcare within the frame work of integrated planning strategies for human progress and production.

The process of treatment and mentorship were interesting. Treatment usually included both the physical and psychological dimensions. The psychological aspect of this healthcare system was what differentiated it from modern medicine and was the main reason for its criticisms. They appeased the gods to understand and establish the cause and prescribed remedy for illnesses. In adopting the psychological method of treatment beyond treating physical symptoms, traditional medicine was relatively effective in treating psychosomatic cases which were not easily treated by the colonial medicine. Herbs divination and water also constituted an important element of the therapeutic process. Another important emphasis in the treatment process was group therapy, rather than treating patients in isolation from their community or society. What makes traditional medicine to be such an enduring institution in Africa is its holistic approach, combining the physical and the spiritual. Although the exact beginnings of modern health services in British Southern Cameroons are not known, it has been established that the area from the time it was peopled was host to most of the things that are responsible for the occurrence of diseases. In fact, the people had constant contact with the soil since they were principally farmers. Worst still, shoe wearing was

conspicuously absent in these communities. So, given that micro-bacteria's are found in the soil, there is the possibility that diseases emerged in the area many years before the imposition of colonial rule [7]. The Community of life that was marked by the sharing of one home by members of an entire family further exposed the people to diseases. The wide spread poverty and the common practice of hunting animals were arguably other contributing factors.

Traditional practitioners decided on the type of traditional medicine and healing methods to be used for a particular illness. The medication administered depended on the type of illness, age and state of the patient. The mode of administration of medication included oral ingestion, steaming, sniffing of substances, cuts or body piercing and ritual performance [8]. In the Bamenda Grassfields, the people performed public ceremonies to banish epidemics particularly smallpox and influenza. Maternity services were rendered by specialists, usually women quite advanced in age. Public sanitation was regarded as a communal responsibility but the uncontrolled straying of animals especially dogs and pigs were a threat to public health. There was equally inadequate water sources which was derived mostly from streams, rivers, lakes or rain water were unhygienic in that these sources were used for collecting drinking water, bathing, washing of clothes and also served as a drinking point for animals.

Another important emphasis in this treatment process was group therapy, rather than treating patients in isolation from their community or society. What makes traditional medicine such an enduring institution in Africa is its holistic approach combining the physical and spiritual. Clyde Kluckhohn, an anthropologist claims that adequate standards of biological normality will not be achieved if Western medicine continues to treat single symptoms or their assumed causes for example the germ responsible for the disease and individual patients than the sick as a group [9]. This situation of treatment of psychiatric disorder by traditional practitioners usually began with the establishment of the relationship of the patient with his family and with the community especially if the cause of the illness was magical.

⁷ H, Rudin., *Germans in the Cameroon, 1884-1914: A case study in Modern Imperialism*, New York, Greenwood Press publisher, 1968.

⁸ Last Murray and Gordon L. Chavunduka, eds, *The Professionalization of African Medicine*, Manchester, Manchester University Press for International African Institute, 1986, pp118.

⁹ Clyde Kluckhohn, *Mirror for Man: A survey of Human Behaviour and social Attitudes*, New York, Fawcett Premier Book, 1970.

⁶Ibid

The Training of Traditional Doctors

In colonial Southern Cameroons, the training of traditional healers was simple and did not involve any formal instruction. Therapeutic knowledge was often acquired through apprenticeship or was hereditary. The notion of inheritance was when all aspects of the traditional medicine were put together and powers transmitted to the apprentice. In effect, the mother, the father or other members of the family handed down their medicinal know how for the treatment of illnesses with the use of plants to their sons and daughters. With this process, the child assisted his father or mother during the process of treatment, listened attentively and learnt the medicine. He or she thus played the role of an assistant. He or she could go to the forest on the instruction of the father or the mother to harvest the various medicinal herbs. As time went on progressively, the apprentice began to practice the treatment of patients. It is important to note that during the period of apprenticeship, the apprentice could not practice the treatment of patients when his or her mentor was still alive. The apprentice (future traditional doctor) was always available around his father or master.

In the transmission of spiritual powers of treatment, the maternal uncles always played a primordial role. This is corroborated by one of our informants himself a traditional doctor:

I have not stolen this medicine. Since my childhood, I have been treating people with good fate and this people always acknowledge the fact that I was a good doctor. I inherited the traditional medicine from my maternal uncle. After the death of my parents, my junior sister and I experience a difficult life in our village. It was for this reason that our maternal uncle came and took us to live with him. I was eight years old. Generally, I assisted in all the house work and was very obedient. One of my uncles was a traditional doctor. He treated almost all diseases. At any moment I heard people screaming in his house, I always rush there to see what was happening. It was for this reason that I became used to it. It all started when he always sent me to go and carry water, make fire, to go and take this or that container and bring to him containing traditional medicine. I also assisted to hold children during circumcision. I saw all what he was using. When I was eleven years old he took me to the forest and showed me the various herbs he uses during treatment. It was after this that he

began to send me to the forest to harvest the various medicinal plants he had shown me. Two weeks before his death, he called me in his room very early in the morning, I sat on his bed and he held my hand with his own hand very tight and he said to me treat patients as I used to do. After his death, I began treating patients till date [¹⁰].

Another method of apprenticeship was through the exchange of certain commodities between the traditional doctor and he who wanted to learn how to treat patients. In this case, the acquisition of traditional medicine and spiritual powers in the Ejahgham, Bakossi, Babungo and Oku communities was gradual. This was because the traditional doctor doubted his apprenticeship until when he prove himself worthy to practice [¹¹]. This particular process of learning was complex as compared to the hereditary method. At a certain point the traditional doctor would not want to show the apprentice all the components of particular medicine. The process of transmission of spiritual powers was always done very early in the morning or late at night. This was because late at night the apprentice will go to sleep at once without having any contact with anybody. It was the same case very early in the morning. The traditional practitioner held tight the hand of the apprentice and evoked the spirits. This was to say you can go and treat people with transparency and honesty.

The third method of apprenticeship or mentorship of traditional doctors was through dreams or vision. A demised family member could decide to transmit in a dream the necessary details of what he or she always treated patients with to another member of the family [¹²]. By so doing, he or she will relate through a dream the components and tell the person what to do and how to go about it. In all, during the learning process candidates acquired knowledge in matters pertaining to the medicinal value and uses of herbs, the causes, cure and prevention of diseases and other forms of suffering. After being initiated and commissioned to treat and to cure they were handed a relic that had been used by their predecessors, with which he evoked their presence and guidance whenever he administered treatment. The trainee then set up a shrine where he received and treated his clients. Many of these shrines were destroyed by the Germans.

¹⁰ Interview with Ndikaka, 85 years, Traditional Doctor, Oku, 20 November 2015.

¹¹ Interview with Keng , 80 years, Traditional Doctor, Mbiame, 15 November 2015.

¹² Discussion with Peter Awong, 82 years, Kumba, a Retired Leprologists, 12 October 2015.

It is evident from what precedes that there existed a relevant indigenous traditional medical system whose legitimacy and acceptance was both absolute and communal. This indigenous approach to healthcare represented a sum total of all knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or societal imbalance. Tied to the natural environment and the belief system of the people, traditional medicine relied exclusively on practical experience and observation handed down from generation to generation. The traditional healthcare system of Southern Cameroonians therefore intertwined with nature as well as with cultural and religious beliefs. The consistent reliance on this medical system for good health prior to the imposition of European colonialism served as a potential for the people's engagement in the diversified traditional economy. The good health that spilled from the traditional healthcare system had a bearing on the vibrant nature of the economy and development as a whole. Development scholars are therefore right in their argument for what they term "health for development". As Grosse and Harkavy argue, expenditures on health are considered as an investment in human resources, contributing to productive capacity [13]. It is in the light of such connection between health and development that we extend the analysis of this paper to social and economic developments in Southern Cameroons societies before the inception of Western medicine.

An Overview of Western Biomedicine in Southern Cameroons

The introduction of biomedicine in Southern Cameroons began in earnest during the era of German colonialism. But it was only in 1908 that meaningful efforts were undertaken by the German Government to battle these diseases in the area. This was when Governor Seitz found out that diseases were wide spread in the colony with ramifications on the exploitative colonial policy that had been put in place. Initially, German Administration and health workers were instructed by the Governor to promote awareness and spread knowledge about the diseases [14]. Measures were taken to inform traditional authorities across the territory that later became known as Southern Cameroons about the serious nature of the diseases. As the awareness campaign was on-going, German health workers began taking measures to establish health posts where the sick could be treated. Throughout German Cameroon as revealed in the 1909 – 1910 report, there were so many patients suffering from one or two diseases [15]. It was this report that urged the authorities to construct clinics, dispensaries and health posts. Regrettably, the cultural beliefs of the people in

which the perception of diseases like leprosy, smallpox and the stigma that went with the diseases were embedded made leper settlements and hospitals approach to be a resounding failure. As a matter of fact, most of the people for fear of the social rejection and stigma refused to show up to be treated [16]. Some believed that there was no cure for the diseases since they saw it as divine punishment. Consequently, the clinics and health posts that were established in Victoria and Mamfe hardly received patients. As the Germans were fashioning strategies to encourage the patients to go to the health post for treatment, the prevalence of diseases heightened.

But unexpectedly, the extension of the First World War to Cameroon in general and in the area that later became known as Southern Cameroons in particular disrupted and terminated the entire German health care system in the territory [17]. Instead of fighting against diseases the Germans had to confront the invading Anglo-French army. This situation was worsened in February 1916 when the Germans were defeated and ousted from Cameroon. This brought to an end the campaign against diseases initiated by the German Government. In March 1916, the German Protectorate of Cameroon was partitioned between Britain and France with the implication that the two powers inherited the health problems in their respective positions of the territory. World War One did not only provide the potential for British involvement in health work but also resulted in the birth of the British Southern Cameroons which constitutes the locale of our study.

British medical work in the territory was made possible by Article 2 of the Mandate Agreement which mandated Britain to improve on the health of the local population. So, it became essential that a policy be framed and adopted which will have in view the definite object of reducing, and ultimately eradicating the diseases that were endemic among the indigenous populations. So the haphazardness that had characterized the manner in which the health needs of Southern Cameroons had to be abandoned in favour of a comprehensive scheme targeting both indigenes and the Europeans. This was the task of the Senior Medical Officer (SMO) who was in charge of medical services in the whole of Southern Cameroons. In putting in place the new scheme, the SMO was expected to work in collaboration with the Nigerian Directorate of Medical and Sanitary Services (DMSS) that was headquartered in Lagos. The joint work by Dr. F. Ross, pioneer SMO for Southern Cameroons and his colleagues at the DMSS in Lagos resulted in more ordinances that laid the foundation for the development of a new health scheme for Southern Cameroons. The legislation that came within this new framework was

¹³ Robert N. Grosse and Oscar Harkavy, "The Role of Health in Development", *Social Science and Medicine*, Vol. 4c, 1980, pp. 165-169.

¹⁴ *Ibid.*, p. 348.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

intended to guide medical practice in Southern Cameroons. The medical sector regulations inherent in the legislation were dynamic given that each phase of the territory's political evolution introduced major changes in health policies [18].

In Southern Cameroons there was a Medical Department headed by a Senior Medical Officer (SMO) who was stationed in Victoria and was in charge with the implementation of decisions taken by the DMSS in Lagos, Nigeria [19]. So, the town of Victoria was the medical administrative headquarters of Southern Cameroons. The health care system in the territory, just as in Nigeria, was intended to fight against diseases and unhygienic conditions all in the hope of improving the health of the people. Consequently, it was the responsibility of the SMO to design medical policies for the territory, supervise all aspects of medical work, and ensure the conduct of research and training. To put it differently, the staffs of the Medical Department were commissioned by their bosses in Nigeria to provide staff and hospitals for the territory, conduct and oversee medical field work, launch campaigns against epidemics, ensure the sanitation of townships and government stations, and engage in mental health and health propaganda.

In an effort to meet this goal, Southern Cameroons was initially divided into four medical administrative districts that corresponded or to four divisions the territory had at the time. The medical administrative districts were Victoria, Kumba, Mamfe and Bamenda. In each of these medical districts was stationed a Medical Officer who managed the healthcare system in his area of jurisdiction [20]. These four medical officers with health administrative functions received and implemented instructions on medical and health matters from hierarchy in Victoria through the District Officers. It was also the medical officers' responsibility to transmit such information to their staff and collaborators, especially Native Authorities and Mission Agencies. This is indicative that private actors in the healthcare sector were all subject to the Medical Officer in the divisions where they carried out healthcare delivery activities. Indeed, the Medical Officers worked collaboratively with paramedical staff like European Nursing Sisters, Senior Nurses, Midwives, N.A. Dispensers and Dressers, as well as Sanitary Officers and mission medical staff. The Medical Officers prepared medical reports based on the information they

received from their subordinates and collaborators in their respective divisions. Such reports which quite often included a rubric on suggestions were sent to the Senior Medical Officer in Victoria through the District Officers and Resident respectively. On his part, the Senior Medical Officer exploited the reports from the Medical Officers to produce a comprehensive report on Southern Cameroon's healthcare situation. Such a detailed report was then forwarded to the DMSS in Lagos, Nigeria through the office of the Resident in Buea.

Colonial Medical Prejudices and Attacks on Traditional Medicine

The racist attitude of whites amounted to numerous health prejudices upon which medical experts built to justify why new healthcare systems were needed. Apart from labeling many diseases as African, the whites tagged the African healthcare system as primitive and ineffective, insisting that there was need for the Western healthcare culture to be brought to Africa since it was coming from a superior race [21]. Even more disturbing was the fact that Europeans' racist attitude led to unscientific ways of naming new diseases. In naming diseases, preference was given to their racial incidence instead of building on their biological, epidemiological or pathological manifestations. Clearly, therefore, the British were under the influence of this medical racist attitude when decisions relating to the new healthcare system were in process. In fact, the decision to undertake health reforms and efforts at achieving them hinged on Britain's definition of herself as racially superior to the Southern Cameroons societies.

Little wonder biomedicine in Southern Cameroons was presented as a substitute to the people's "primitive" cultural values and beliefs. In this light, the development of a new healthcare system came in the context of the presentation of Western scientific medicine as the only true and superior form of medicine. Baronov broadly describes the racist understanding of medical reforms in Africa, stressing that "it was a question of explaining to the ignorant African masses that the enlightened European was bringing them a radical, foreign concept referred to simply as medicine [22]". No doubt medical reports by the health staff deployed by the British are replete with evidences on the belittling and demonizing of the indigenous traditional healthcare

¹⁸ NAB, File No. Sca/1927/1 "Labour Ordinance" in the Miscellaneous Medical Correspondence, Victoria Division

¹⁹ NAB, File No. Sc/1928/3, Hospital fees: General Correspondence for the procedure in medical correspondence.

²⁰ V. J. Ngoh, *History of Cameroon Since 1800*, Limbe, Presbook, 1996. p. 56.

²¹ Olumwullah, A., *Disease in the colonial State : medicine, society and social change among the Aba' Nyole of Western Kenya*, Greenwood Press, Westport, Connecticut, 2002.

²² Baronov, D., *The African Transformation of Western Medicine and the Dynamics of Global Cultural Change*, Philadelphia, Temple University Press, 2008.

system [23]. The healthcare system in Southern Cameroons was therefore framed to demonstrate Britain's superiority over the ethnic communities in the territory.

Considering the complexity of its practice and procedures, traditional medicine was vehemently denigrated, misrepresented and marginalized [24]. Opposition to it was very strong among missionaries, colonial officials, doctors and nurses who all constituted the basic colonial medical personnel. Due to necessity of treatment, most indigenous population continued to depend on indigenous healers much to the dismay of colonial authorities who sought ways to permanently eradicate, minimized or discredit and its appeal through ordinances. Unlike in other parts of Africa colonial administration offered limited space for traditional doctors in Southern Cameroons to practice and their healing practices were closely monitored [25]. A number of reasons are advanced for such regulations, traditional doctors treated people in rural areas where hospitals were not in existence at little or no cost, and they also treated diseases like mental disorders generally neglected by colonial medical service. Nevertheless the practices of indigenous healers were not considered very dangerous to warrant drastic measures for its eradication other than demonstration of the superiority of biomedicine. Because of its effectiveness, the indigenes continued to rely on traditional medicine during the colonial era.

Activities of traditional doctors, isolated from their social and political functions were a minor threat to the colonial medicine. They posed little commercial threat and their knowledge of plants greatly advanced the western pharmaceutical industry. Fear of competition with the colonial medical service ensured that competition was reduced. Rather than having western medicine or European doctors compete against one another, they invoked racial solidarity against all types of African practitioners [26]. The colonial administration was in some instances supported in the use of traditional medicine by local rulers who were supposed to be custodians of tradition. For example in February 1955 following the refusal of the M.O. for Victoria to approve a drug requisition for the Bonjongo Dispensary, Chief Efesoa wrote to the D.O. of Victoria: "if we are really serious to overcome the

village superstition by gradually inducing the inhabitants to inculcate the supremacy of colonial medicine, we must not give room for doubt and less of confidence [27]". This was an invitation to health personnel of the colonial medical service to help combat smallpox that was ravaging Efesoa's village rather than abandoning sick villages to the mercy of traditional doctors. The Chief realized that most smallpox patients were reluctant to consult at the village dispensary partly because the prescribed drugs could not be obtained at the spot. This contributed in increasing the worth of traditional doctors who provided medication on the spot.

In the 1940s, following the reorganization of healthcare in Southern Cameroons, the practice of traditional medicine witnessed a number of challenges. During this period a number of ordinances were introduced to regulate public health. Two of the ordinances directly affected the practice of traditional medicine: the Pharmacy Ordinance of 1945 and the Dentist Ordinance of 1954 [28]. Both ordinances limited the activities of traditional healers while some provisions of the Criminal Code relating to the preservation of human life criminalized traditional medicine, discredited its practitioners and in some instances served as the basis for penalizing their excesses.

Three factors accounted for the regulation of traditional medicine. First, colonial authorities were quick to accuse traditional doctors for neglecting basic hygiene in the treatment processes. The equipment used such as knives, razor blades, sticks and the manner in which they handled both human and animal blood created anxiety among colonial officials who described it as fetish. This is not to say the processes of traditional medicine were generally unhygienic as some desterilized their equipment with the use of heat from fire or juice from citric fruits like lemons. Second, the misuse of poisonous substances and medications of indigenous healers was rarely standardized and comprised a mixture of a variety of herbs. This regulation of traditional medicine was also put in place to prevent medical malpractices by traditional doctors that were not different from those committed in the hospitals [29]. This led to an indirect recognition of the lapses of conventional medicines. It is probable that the ordinances were intended to fight competition between African traditional doctors and colonial health personnel thereby restricting the practice of health care delivery to Europeans. These colonial prejudices and attacks notwithstanding, traditional medicine remained

²³ NAB, File No. B.99/Vo. 1, Annual Medical and Sanitary Reports.

²⁴ Murray, L. and Chavunduka, G. L., eds., *The Professionalization of African Medicine*, Manchester, Manchester University Press for International African Institute, 1986.

²⁵ NAB File No.Sc(1931) 1, Medical Quarterly and Yearly Report, 1931, p 8.

²⁶ Waite "Traditional Medicine and the Quest For National Identity" p.235, Johnson, "An All White Institution"

²⁷ NAB,File No. Sc(1936) 1, spreading and outbreak of Infectious Diseases, p 166.

²⁸ NAB, File No. B.99/Vol. III, Annual Medical Report, 1954/55.

²⁹ NAB File No.Sc(1931) 1, Medical Quarterly and Yearly Report, 1931, p 8.

relevant in Southern Cameroons, with many indigenous people relying on it for their medical welfare.

Continuing Importance of Traditional Medicine in Healthcare Delivery

The British colonial administration in Southern Cameroons introduced and developed Western biomedicine to address the diseases that were responsible for the high death rate. In doing so, efforts were to undermine traditional healthcare practices which were presented by colonial medical officers as heathen and uncivilized. However, the practice of traditional medicine continued throughout the colonial period, with large portion of the indigenous population depending on it for their medical welfare. This continuing importance of traditional medicine hinged on a number of forces. Traditional medicine was born out of the people's customs, experience, environment and the indigenes therefore had confidence in its approach and method. Because of the wide knowledge of traditional healers in the treatment of a variety of diseases and its efficiency, traditional medicine continued to be relevant throughout the colonial period. Besides, certain diseases were better treated with traditional medicine than western medicine, for instance epilepsy and psychiatric disorders [³⁰].

The persistence of traditional medicine was encouraged by its affordability. The poor rural masses who could not afford to pay for drugs in the pharmacies or hospitals in town preferred the cheaper prescriptions of traditional healers. These prescriptions or treatments usually took the form of livestock like chicken, goats or pigs while pharmaceutical drugs cost several pounds, and only very few indigenes could afford. This partly explains the drop in hospital attendance in 1933 following the introduction of hospital fee [³¹].

The continuing importance of traditional healthcare system was also due to its accessibility, contrary to conventional medical facilities which were generally located in towns and urban centers [³²]. The unequal distribution of health facilities between urban centers and the disadvantaged population in rural areas caused traditional medicine to remain at the heart of the people's healthcare. Consequently, the population tended to rely on the readily available services of traditional healers. In addition, the simple instruments such as calabashes, feathers, herbs and animals used by traditional healers did not scare patients as the needles, injections and x-ray machines possibly did to many of them during systematic health campaigns. Treatment usually did not take lengthy procedures; little time was

lost unlike in the hospital where the patient might cue up for several hours. Also, the hospitality of traditional doctors continued to attract patients. One other factor is the fact that traditional doctors treated the illness and the patient as a whole. Treatment at times involved the cleansing of the entire family or whole community in a generalized crisis and its goal was to reduce tension. Patients' families were followed up and their total environment. This was due to the belief that illnesses or human suffering were caused by witchcraft, magic or mystery.

The traditional healthcare system in Southern Cameroons communities represented an improved health mechanism with a direct bearing on improved social and economic conditions. Hence, the benefits of the indigenous healthcare system were evident in the amelioration of the livelihood of the people as they were able to engage in numerous economic activities. As a matter of fact, the people's healthcare system was relevant to their basic needs and general advancement. The goal at the time was to tap the health system as a strategy for guaranteeing adequate food, shelter, clothing and essential community services such as safe drinking water, transport and educational facilities [³³]. In both the centralized and decentralized societies, healthcare systems therefore intertwined with the advancement of the people. It has been established that a healthier population suffers less debility and disability and can render the people's involvement in economic developmental activities more effective. This was the outcome of the traditional healthcare system in Southern Cameroons.

Economic life in traditional societies across Southern Cameroons centered on hunting, food gathering, animal herding, and farming. Generally, the traditional or peasant economic systems were characterised by simplicity of technology. In societies across the territory, productive units were small, and all traditional economies – fishing, farming, cattle rearing etc – were organized in small units of production [³⁴]. That is, each productive unit was made up of few people. The most important economic unit was the household that needed to be healthy in order to effectively participate in the varied traditional economy. The technology was simple, and was incorporated into the total system.

³³Mokake, M. F., "Public Health and Public Health management in British Southern Cameroons", 1922-1961: The case of Victoria Division, MA Dissertation in History, University of Buea, 2011.

³⁴A. L. Forkusam, "The Evolution of Health Services in the Southern Cameroons under British Administration 1916-1945 DES Dissertation University of Yaounde, 1978, pp 116-123

³⁰ Discussion with Ndinkaka oku, October 2014

³¹ NAB. File No. Sc(1928)2 Medical Quarterly and Yearly Reports 1928-1930.

³²D.Lantum The Pros and Cons of Traditional medicine ABBIA, Cameroon cultural Review No.34-35-36-37

The technology was simple in the sense that the numbers of tasks involved in any productive activity were few; usually it is the skill of a single or two producers which carries production from the beginning to the end. According to Fanso traditional societies depended on very simple tools, and specialization was only limited in that household always produced what was needed in the homes [³⁵]. For example, the Bamenda Grassfields populations were farmers who made a living by a skillful method of crop cultivation. Any year when there was a good rain and good health, each household harvested large quantities of maize, coco yams and other food crops. It is important to note that they used simple technologies, which involved simple tools requiring only energy to operate (e.g. cutlasses, hoes, knives, etc). Similarly, the task structure was simple – a man with his children and wife or wives constituted a productive unit and each person was supposed to be healthy for the production to be effective. Good enough, the traditional healthcare system, to an acceptable extent, guaranteed the good health the people needed to participate in this productive traditional economy. There was a sex based division of labour and tasks were assigned based on age.

In most cases the apprenticeship system in non specialised fields was short given that a person learned his productive skills in the ordinary business of growing up among family members [³⁶]. Usually tasks were apportioned to the appropriate healthy persons without much regard to differences in skill or productivity. In fishing communities such as Victoria (now Limbe), Ekondo Titi, and Idenau (peoples of the coastal zone of Southern Cameroons), healthy adult men and male children engaged actively in fishing while the women and girls engaged in fish processing, preservation and marketing. The male children of fishermen assisted their fathers in fishing and in the act understudied him and after some time they were able to effectively perform the same activity. Similarly, female children understudied their mothers as they assisted them in the act of fish processing, preservation and marketing. After some time they could effectively perform these activities with relative ease. It was this transmission of production knowledge from generation to generation that rendered sustainability of the economy possible. The transmission of knowledge was done concurrently with the transmission of knowledge on the healthcare system given that production was tied to healthcare. In fact, the population needed to be

³⁵ V. G. Fanso, *Cameroon History for Secondary Schools and colleges*, Volume 2: The colonial and post-colonial period London: Macmillian, 1987.

³⁶ F, Etoga Eily, *Sur les Chemins de Developpement: Essai D'Histoire des Faits Economiques du Cameroun*, Yaounde, Centre d'Edition et de Production de Manuels et d'Auxiliaires de l'Enseignement, 1968, pp. 35-43.

healthy to be able to engage in fishing, farming, hunting, animal rearing, craft works and other economic endeavours.

The population of this area engaged in agriculture as their main economic activity with the intension of satisfying their basic agricultural needs. They also practiced animal rearing, hunting, fishing and trading activities [³⁷]. The cultivation of crops like cocoyams, beans, and maize just to name a few were for family needs. Amongst these activities hunting, fishing and animal rearing exposed the people to some of the endemic diseases that afflicted them. They carried out fishing by the use of nets and a long funnel shaped baskets, which they plunged in the numerous river courses and streams. Vectors of river blindness and mosquitoes infested the watercourses and penetrated their host as the fishing population stayed in water for fishing purposes. The animals they reared included; goats, sheep, fowls, dogs, cattle and horses. The domestic animals virtually lived with them and rendered their surroundings dirty and exposed to health problems. These animal harboured ticks and lice which are vectors of typhus fever, thus, they acted as direct and indirect vectors of diseases.

In the domain of handicraft, the dissemination of knowledge on the production of various works of arts like the weaving of caps, mats, bags, baskets, carving, embroidery and potting. Those who preferred carving were given extensive knowledge on it. For example in the leprosy settlements in British Southern Cameroons, the patients had the technical knowhow required for the transformation of wood into drums, horns, bolls and many other arts objects [³⁸]. Given that the selling of the artifacts they fabricated was a lucrative economic activity, the former lepers who were specialized in handicraft now had a guaranteed source of income. Besides, the patients who received training in shoe mending returned to their communities as happy and fulfilled people. Generally, the knowledge they acquired on handicraft influenced the lives of Southern Cameroonians in diverse ways. Most of them became self-reliant in spite of the deformities caused by the diseases.

Overall, traditional healthcare in colonial Southern Cameroonian societies was seen as an asset that was indispensable in the improvement of livelihoods through varied systems of production. The production system as already pointed out hinged on the healthcare system since it ensured that there was a healthy population for the numerous production tasks. What sustained the traditional economy, then, was not

³⁷ Ibid

³⁸ C. Asongwe, "The Fight Against Leprosy in British Southern Cameroons 1922-1961: An Historical Evaluation", MA Dissertation in History, University of Yaoundé 1, 2014.

just the sufficient supply of manpower, but a healthy labour force. Indeed plenty of healthy and strong men and women were needed to work the land and open new fields. Without a healthy labour force, the traditional economy was limited as this had a direct bearing on farming, fishing, hunting, animal husbandry and craftworks. Accordingly, in those days, the healthcare system was valuable and institutions that regulated healthcare as well as the healers and herbalists played crucial roles in Southern Cameroons' economy. The people in both the forest and savannah zones were constantly threatened by endemic diseases such as malaria. In the late 19th century, colonial doctors estimated that up to 20% of all young children living in these areas died from malaria. Leprosy was common, especially in the humid areas, and smallpox posed a threat all over the savannah. But by becoming associated with the traditional economy, traditional healthcare was able to enhance the livelihood of the people despite colonial prejudices and attacks.

CONCLUSION

This paper has examined the continuing relevance of traditional medicine in colonial Southern Cameroons despite its undermining by British colonial officials and medics. With roots traced to the pre-colonial era, traditional medicine constituted an effective mechanism of healthcare delivery. But the coming of biomedicine in a context of European colonialism opened the way for a consistent attack on indigenous healthcare practices. In most parts of Southern Cameroons, medical facilities were developed with the intent of making preventive and curative healthcare available to the local population. Surprisingly, a cross section of the indigenous population kept their trust on traditional medicine, thus permitting it to survive colonial attacks. The paper has discussed the nature and relevance of traditional medicine in pre-colonial Southern Cameroons. It has also discussed the development of Western medicine in the territory alongside colonially-inspired prejudices and attacks against traditional medicine. Despite these attacks, traditional medical practitioners kept their worth by addressing the people's health problems in ways that enhanced collective welfare. Hence, the paper concludes that traditional medicine reduced the prevalence of diseases and encouraged socio-economic development, with a resultant imprint on the livelihood of the local population. In fact, the resultant treatment of some of these diseases was beneficial to the health of the population and facilitated in many ways the social and economic development of colonial Southern Cameroons.

REFERENCES

1. Prince, R. J., & Marsland, R. (Eds.). (2013). *Making and unmaking public health in Africa: Ethnographic and historical perspectives*. Ohio University Press.
2. Marynez, L. (1992). *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940*, Cambridge, *Cambridge University Press*, 76.
3. Rudin, H. (1968). *Germans in the Cameroons 1884-1914: A Case Study in Modern Imperialism*, New York, *Greenwood Press*, 345.
4. Emmanuel, N.N. (2011). "Traditional Health Care System and Challenges in Developing Ethnopharmacology in Africa: Example of Oku, Cameroon", *Ethno Med*, 5(2), 133.
5. Last, M., & Gordon, L. (1986). Chavunduka, eds, *The Professionalization of African Medicine*, Manchester, Manchester University Press for International African Institute, 118.
6. Clyde, K. (1970). *Mirror for Man: A Survey of Human Behaviour and Social Attitudes*, New York, *Fawcett Premier Book*, 81.
7. Discussion with Keng. (2014). 80years, A traditional doctor, Mbiame.
8. Interview with Ndikaka. (2014). 85 years, Traditional Doctor, Oku.
9. Discussion with Peter Awong. (2015). 82 years, Kumba, a Retired Leprologists, 12.
10. Robert, N. (1980). Grosse and Oscar Harkavy, "The Role of Health in Development", *Social Science and Medicine*, 14C, 165-169.
11. National Archive Buea (Cameroon) File No. Sca/1927/1 "Labour Ordinance" in the Miscellaneous Medical Correspondence, Victoria Division
12. National Archive Buea (Cameroon) File No. Sc/1928/3, Hospital fees: General Correspondence for the procedure in medical correspondence.
13. Ngoh, V. J. (1996). *History of Cameroon since 1800*, Limbe, Presbook, 56.
14. Olumwullah, A. (2002). *Disease in the Colonial State: Medicine, Society and Social Change among the Aba' Nyole of Western Kenya*, Greenwood Press, Westport, Connecticut.
15. Baronov, D. (2008). *The African Transformation of Western Medicine and the Dynamics of Global Cultural Change*, Philadelphia, Temple University Press.
16. National Archive Buea (Cameroon) File No. B.99/Vo. 1, Annual Medical and Sanitary Reports.
17. National Archive Buea (Cameroon) File No. Sc. (1931). 1, Medical Quarterly and Yearly Report, 8.
18. Waite. "Traditional Medicine and the Quest For National Identity" 235, Johnson, "An All White Institution"
19. National Archive Buea (Cameroon) File No. Sc. (1936). 1, spreading and outbreak of Infectious Diseases, 166.
20. National Archive Buea (Cameroon) File No. B99/Vol.111, Annual Medical Report, 1954/1955
21. National Archive Buea (Cameroon) File No. Sc. (1928). 2 Medical Quarterly and Yearly Reports 1928-1930

22. Lantum, D. The Pros and Cons of Traditional medicine ABBIA, Cameroon cultural Review No.34-35-36-37
23. Mokake, M. F. (2011). "Public Health and Public Health management in British Southern Cameroons", 1922-1961: The case of Victoria Division, MA Dissertation in History, and University of Buea.
24. Forkusam, A.L. (1978). "The Evolution of Health Services in the Southern Cameroons under British Administration 1916-1945 DES Dissertation University of Yaounde, 116-123.
25. Fanso, V. G. (1989). Cameroon History for Secondary Schools and Colleges, 2, *The Colonial and Post-Colonial Periods*, London, Macmillan.
26. Etoga, F., Eily. (1968). Sur les Chemins de Developpement: Essai D'Histoire des Faits Economiques du Cameroun, Yaounde, Centre d'Edition et de Production de Manuels et d'Auxiliaires de l'Enseignement, 35-43.
27. Asongwe, C. (2014). "The Fight Against Leprosy in British Southern Cameroons 1922-1961: An Historical Evaluation", MA Dissertation in History, University of Yaoundé 1, 2014.