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The development of modern medical and health services in the warri/delta province, Nigeria 1906-1960

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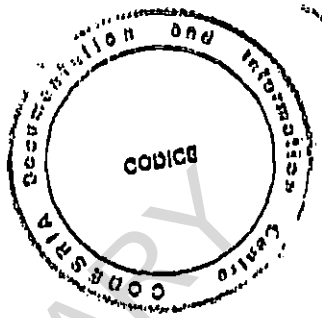
THE DEVELOPMENT OF MODERN MEDICAL AND HEALTH SERVICES IN THE WARRI/DELTA PROVINCE, NIGERIA 1906-1960



By

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ABSTRACT

This study examines the development of modern medical and health services in the Warri/Delta Province during the colonial period, emphasizing policies affecting development, their implementation and factors influencing acceptance or rejection of modern treatment by the people. It also highlights the contributions of the Delta peoples to the development programmes.

Collaboration between governmental agencies (central, provincial, local and regional governments) on the one hand and governmental and non-governmental agencies (Christian missions, commercial companies, individuals and communities) on the other hand constituted the bed rock of the development of modern medicine in the Warri/Delta Province. To maintain standards the Medical Department approved the opening of, and supervised all medical institutions. Between 1906 and 1929, the colonial state instituted modern medicine by opening hospitals at the principal towns of Warri, Sapele and Forcados and dispensaries at the other towns. Only emergency measures reached the rural communities during serious out-breaks of diseases. In 1930, the colonial government encouraged the NAs and the Christian Missions to institute medical and health facilities in the rural areas giving them financial assistance on some occasions. It also authorised the UAC to open dispensary services for its workers in 1942.

The government proposed an expansion of urban and rural medical facilities in 1945, in its Ten Year Development Plan which it jointly financed with the British government to satisfy agitations for more medical facilities. It revised the plan in 1951 because shortage of manpower and materials frustrated implementation of most

projects. The successful implementation of the Revised Plan, which was supplemented with the Western Regional government's health policy of 1952, resulted in a meaningful expansion of urban hospitals, NA dispensaries and maternity homes, public health measures as well as instituting rural hospitals. All the non-governmental agencies also expanded their medical activities. By 1960, each clan had at least one modern medical institution established in its area.

The acceptance of modern medicine by the Delta peoples increased with the expansion of medical facilities and the educated elite. Between 1906 and 1929, only Christians, public servants and the educated elite, living mostly in the towns appreciated modern medicine because of their understanding and availability of medical facilities. Likewise, the rural dwellers started appreciating modern medicine from the 1930s when the facilities became available to them. Enlightenment campaigns and the presence of their western educated relatives who now lived in the rural areas as school and church teachers and public servants also influenced them. Their acceptance stemmed mainly from the effectiveness of some modern methods of treatment. Between 1945 and 1960 more interest groups had started clamouring for modern medical facilities which, in addition to medical care, had been conceived as manifestations of modernity.

Through experience, however, the Delta peoples had also identified diseases and areas of health care in which modern medicine did not prove effective. Moreover, it did not attempt to solve their socio-economic problems. For those health and socio-economic problems most Delta peoples continued to employ traditional medicine. Thus, what eventually emerged amounted to medical pluralism.

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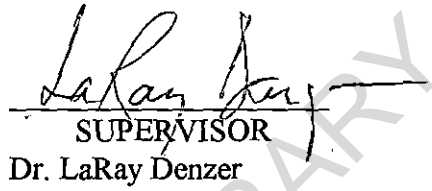
CERTIFICATION

I certify that this work was carried out by Mr. Samuel Chukwudoruem Agubosim in the Department of History, University of Ibadan, Ibadan.



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January, 1997

DEDICATION

Dedicated to members of my family who missed me most and suffered most during the period of my programme.

Ukamaka Victoria	(wife)
Ezinne Chika	(daughter)
Onyemaechi Chinaka	(Son)
Oluchi Chidinma	(daughter)

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ABBREVIATIONS

ADO	Assistant District Officer
Ag	Acting
Asst	Assistant
BELRA	British Empire Leprosy Relief Association
CMS	Church Missionary Society
CSG	Chief Secretary to Government
CSO	Chief Secretary's Office
DDMS	Deputy Director of Medial Services
Dist	District
Div	Division
DMS	Director of Medical Services
DO	District Officer
Dr	Doctor
Ed	Editor
Eds	Editors
Fed	Federal
Fn	Footnote
Govt	Government
JAH	Journal of African History
JHSN	Journal Historical Society of Nigeria
LA	Local Authority
MH	Ministry of Health
MO	Medical Officer

NA	Native Administration/Authority
na	Not Available
NAI	National Archives Ibadan
NAs	Native Administrations/Authorities
ND	No Date
No	Number
NP	No Publisher
NS	Not Signed
P	Page
PP	Pages
PWD	Public Works Department
RCM	Roman Catholic Mission
Rev	Reverend
RWEC	Rural Women Education Centre
San	Sanitary
Sap	Sapele
SDA	Seventh Day Adventist
SDO	Senior District Officer
Sen	Senior
SMO	Senior Medical Officer
St	Saint
Sup	Superintendent
SWPs	Secretary Western Provinces
SNPs	Secretary Northern Provinces

UAC	United African Company
Ughel	Ughelli
UNICEF	United Nations International Children's Emergency Fund
USA	United States of America
Vol	Volume
WA	West Africa
WAMJ	West African Medical Journal
War Prof	Warri Provincial Office
WHO	World Health Organisation
WI	Western Ijo
WP	Warri Province

PREFACE

To date medical history has remained a neglected aspect of Nigeria's social history. Only few historical works on other subjects in Nigeria, as in the area of study, make cursory remarks on health issues.[1] In fact no trained historian has written a detailed medical history of Nigeria or any part of it.

Existing works on the development of modern medicine in Nigeria consist of studies by specialists in the medical profession. They include the works of R. Schram and A. Adeloye as well as a great number of journal articles on various tropical diseases.[2] Social Scientists and other scholars have only started recently to assemble articles on a wide range of health issues on Africa with very few on Nigeria.[3]

This study aims to examine the development of modern medical services in a

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1. See for example, J.F.A. Ajayi, *Christian Missions in Nigeria, The Making of a New Elite, 1841-1891* (London: Longman, 1965), pp. 159-162;. E.A. Ayandele, *The Missionary Impact on Modern Nigeria 1882-1914: A Political and Social Analysis* (London: Longman, 1966), pp. 84-85, 247, 249, 279, 343 and 345; O. Ikime, *The Isoko People: A Historical Survey* (Ibadan: Ibadan University Press, 1972), pp. 78-80.

2. R. Schram, *A History of the Nigerian Health Services* (Ibadan: Ibadan University Press, 1971); A. Adeloye, (ed.) *Nigerian Pioneers of Modern Medicine: Selected Writings* (Ibadan: Ibadan University Press, 1977); A. Adeloye, *African Pioneers of Modern Medicine: Nigerian Doctors of the 19th Century* (Ibadan: Ibadan University Press, 1985). See the volumes of the *West African Medical Journal* 1927-1937, 1958-1960; *Dokita* 1960.

3. See for example, Toyin Falola and Dennis Ityavyar (eds.) *The Political Economy of Health in Africa* (Ohio: Ohio University Centre for International Studies, 1992); E. Sabben Clare, D.T. Bradley and K. Kirkwood (eds.) *Health in Tropical Africa During the Colonial Period* (Oxford: Clarendon Press, 1980).

part of Nigeria - the Warri/Delta Province. It examines the main policies that determined the development of medical and health services in Nigeria, their implementation in the province and the response of the Delta peoples to such services. It also highlights the contributions of the Delta peoples to the development of modern medicine in their area.

The study is an attempt to fill a gap in historical research and provoke more scholarship on the subject. It would also serve as a useful guide to policy makers formulating new policies because health and medicine have been major areas in policy formation since the colonial period. The colonial administration tackled both curative and preventive as well as disease control measures in the townships and rural areas. Undoubtedly, an adequate study and analysis of the initial policies and their implementation will give an insight into how to grapple with present and future health problems. To appreciate the necessity for this study, a review of existing literature is imperative so as to demonstrate the paucity of relevant literature.

THE STATE OF STUDY ON NIGERIAN MEDICAL HISTORY

We have noted that the majority of study in medical history has been produced by medical practitioners, medical researchers and social scientists. Naturally these works concentrate on analysis of diseases and treatment, scientific research and policy formation. Here these works are reviewed under three categories:

(1) The works on a world-wide evolution of the sciences of medicine;

(2) The works on colonial medical history in Africa; and

(3) Works that deal specifically with Nigeria.

The works that centre on a world-wide evolution of the science of medicine are Douglas Guthrie's *A History of Medicine* (1945), E.H. Ackernecht's *A Short History of Medicine* (1955), H.E. Sigerist's *A History of Medicine* (1961), and Iglis Brian's *A History of Medicine* (1965).[4] These authors broadly surveyed the practice of medicine from the pre-historic times to the present, touching on the different centres of early civilisation. They adopted a similar approach and differed on their emphasis and focus on the different centres of early civilisation. For example, Sigerist gave greater attention to Greek, Hindu and Persian medicine, while Ackerknecht focused on the early civilisation of Egypt, Asia and America.[5]

None of these works treats the introduction of a foreign system of medicine into alien communities. They, however, indicate that traditional medicine which the authors labelled primitive medicine, was practised in all parts of the world at one time or the other and continues to be practised in many societies.[6] Furthermore, the authors present vital background on the 19th century developments in medical science and policy. Ackerknecht shows the origins of the present emphasis on specialisation by medical practitioners.[7] For example, public health did not only become a special

4. D. Guthrie, *A History of Medicine* (London: Thomas Nelson and Sons, 1945); E.H. Ackerknecht, *A Short History of Medicine* (New York: Ronald Press, 1955); Iglis Brian, *A History of Medicine* (London: Morrison and Gibbs, 1965); H.E. Sigerist, *A History of Medicine vol.II* (Oxford: Oxford University Press, 1961).

5. Sigerist, p.v; Ackerknecht, pp.I & II.

6. Guthrie, pp. 3-5; Ackerknecht, pp. 11-12; Brian, pp. 6-7.

7. Ackerknecht, pp. 187-194.

area of practice, its scope also widened to include sanitation, hygiene and other aspects of community health such as drainage and sewage disposal, potable water supplies, the isolation of infectious diseases, better housing and the control of contagious diseases.[8] Indeed, the period of exploration of Africa coincided with these new trends in Western medicine which influenced medical policy in Africa.

The second category of works focuses on the introduction of modern medicine to different colonial African territories. In 1958, H.E. Squires assessed the medical history of Sudan, emphasizing the evolution of the Civil Medical Service from Military Service and the activities of Christian Missions and the colonial government.[9] In the same year, E. Burrow's study of medicine in South Africa to the end of the 19th century emphasised the pioneering medical activities of the Dutch East Indian Company with the Christian missions and the colonial government not coming in until later.[10] P. Laidler and M. Gelfand filled in the later historical period by reviewing the medical developments in South Africa during its colonial period.[11] The medical activities of the Christian missions and the colonial government were further emphasised by W.D. Foster in his analysis of the development of modern medicine in

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8. Guthrie, pp. 391 ff.

9. H.E. Squires, *The Sudan Medical Services* (London: William Heinemann, 1958), pp. XII-138

10. E. Burrows, *A History of Medicine in South Africa Up to the 19th Century* (Capetown: NP 1958), pp.17-54, p.229.

11. P. Laidler and M. Gelfand, *South Africa, Its Medical History and Social Study* (Capetown: Struik P.T.Y., 1971), pp.3-40, 79-116.

Uganda.[12] The works of R. Schram and A. Adeloye on Nigeria which we shall examine more fully later belong to this category of works. Schram stressed the medical work of the Christian missions, the colonial government and some international bodies[13] Adeloye emphasised the contributions of the Nigeria pioneer doctors to the development of modern medicine through their services and their writings.[14]

A common feature to these works was their preoccupation with missionary and government medical work. Christian missions often pioneered institutional practice of modern medicine in the colonies. The experience of Uganda and Nigeria illustrates this. In Uganda, a missionary team headed by Dr. J. Smith arrived in 1876 and by 1892, the medical doctors had established a dispensary, later followed by a hospital at Mengo in 1897.[15] In Nigeria, Hope Waddel and his mission's medical agents arrived in 1855 at Calabar and in 1856, Zerub Baille, a medical doctor opened a dispensary at Duke Town.[16] The medical advisers of the Yoruba mission also established a dispensary about the same time and a hospital at Abeokuta in 1895.[17]

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12. W.D. Foster, *The Early History of Scientific Medicine in Uganda* (Dar es Salam: East African Literature Bureau, 1974), pp. 38-43.

13. Schram, pp. 52-156, 228-317.

14. Adeloye, *African Pioneers of Modern Medicine: Nigerian Doctors of the 19th Century,* p.54.

15. Foster, pp. 2-13, 43.

16. Adeloye, *African Pioneers of Modern Medicine: Nigerian Doctors of the 19th Century,* p.45.

17. Schram, pp. 62 and 426.

Another trend emphasised in these works was the role of the European military medical service in institutionalising Western medicine in the African colonies.[18] For example, in 1863 Nigeria's first government hospital started at Lagos as a reception centre for sick seamen of the Royal Navy.[19] On the other hand none of these works highlighted the response of the African peoples or their contributions to the development of modern medical services in their communities.

The works of R. Schram and A. Adeloye constitute the major studies dealing specifically with health services in Nigeria. Schram reviewed the development of modern medicine in Nigeria from the time of early European contacts in 1460 to the end of colonial rule in 1960. He summarised all aspects of medical and health services in Nigeria, but stressed the contributions of the Christian missions, the central and regional governments to the establishment of medical institutions and the campaigns for the eradication of particular diseases by the colonial administration as well as by international bodies. His book constitutes an important compendium of facts. According to him:

> This is the first attempt to put together the story of Nigeria (and) inevitably I will have left out much interesting detail in such a summarised account.[20]

Because of this wide coverage, Schram did not analyse the development of modern medicine in Nigeria. Even in his narrative, my area of study received very little

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18. *Ibid.*, pp. XVIII, 103 and 105; Foster, pp. 38-39.

19. Schram, pp. 103 and 105.

20. *Ibid.*, pp.XIII, XVI, 224, 229, 116-139, 170-175, 312-330.

attention. He mentioned few hospitals and listed others in the appendix.[21] Nor did he highlight the Nigerian peoples reactions to different aspects of modern medicine or their contributions to establishing them.

Adeloye surveyed the contributions of the Nigerian pioneer doctors in two separate works. He first highlighted their contributions to medical research and treatment of tropical diseases by editing their writings.[22] In the second work, he emphasised their contributions as public servants and their socio-political activities. He focused more on the 19th century and thus provided us relevant information on the 19th century ordinances and medical legislations for Lagos that applied to other areas in Nigeria in the 20th century.[23]

Furthermore, we get some insight into the problems of implementation of medical policies in Nigeria from M.C. McCorkmick's reminiscences as a missionary nurse at Ogbomosho between 1925 and 1941.[24] Apart from Schram, Adeloye and McCormick no other scholar has ventured into the historical development of Nigeria's medical and health practices. We rather have a number of articles that centre on the aetiology, incidence, research results and treatment of various tropical diseases while a few deal with hospital administration, medical policies and problems

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21. *Ibid.*, pp. 86, 224, 299, 426, and 430.

22. Adeloye (ed.) *Nigerian Pioneers of Modern Medicine: Selected Writings.*

23. Adeloye, *The African Pioneers of Modern Medicine, Nigerian Doctors of the 19th Century,* p.54.

24. M.R. McCormick, *Memoirs of Nigerian Days 1925-1941* (Tennessee: N.P. 1981), pp. 85-94.

of the medical department. These provide important clues for the historian concerning the state of health of various Nigerian peoples and indigenous ideas concerning disease and health care that partially conditioned their acceptance or rejection of modern practices. We therefore proceed to review a few samples of these articles.

In 1931, E.C. Braithwaite identified malnutrition, parasitic infection and trauma as causes of tropical ulcers.[25] In the same year, R.M. Burnie studied cases of ulcers in Kano and came to the conclusion that they fell within the type called "Ulcus Tropicum" (tropical ulcers).[26] E.C. Smith, also in the same year, gave the research result of an experiment on the roles played by various organisms found in all cases of tropical ulcers.[27] J. A. Young identified termites as another cause of ulcers stating that they could transmit the disease from infected soil.[28] As a result of research carried out at Aba in 1933, J.S. Robinson recommended grafting as the most effective method of treating cases of ulcers.[29] Similar studies were done for most tropical diseases prevalent in Nigeria including: Malaria, yaws, leprosy, smallpox and typhoid

25. E.C. Braithwaite "Ulcers" *WAMJ*, 4 (4), 1931, p.93

26. R.M. Burnie, "Observations on Tropical Ulcers" *WAMJ*, 4 (4), 1931, pp.82-85.

27. E.C. Smith, "Experimental Tropical Ulcers" *WAMJ*, 4 (4), 1931, pp.87-88.

28. J.A. Young, "Ulcus Tropicum" *WAMJ*, 5 (3), 1932, p.49.

29. J.S. Robinson, "Treatment of More Severe cases of Simple Tropical Ulcers" *WAMJ*. 6 (4), 1933, pp.67-68.

fever.[30]

A number of authors evaluated general administrative problems in medical institutions in Nigeria as well as the problems of the medical profession as a whole. In 1932, H.B. Lee discussed the lack of division of labour in medical institutions in Nigeria laying out the duties of each medical staff unit and advised that each worker should strictly keep to his or her own duties.[31] Towards the end of colonial rule, Adeniyi Jones criticised the age-long dichotomy between preventive medicine and curative medicine, suggesting that in developing countries, public health and preventive medicine should be part of hospital practice.[32] Ulli Beier and U. Nwokolo decried the practice of modern medicine by all kinds of pseudo-doctors and highlighted the evil effects of their practices.[33] By this time modern medicine had

30. F.W. Purcell, "Aetiology of Yaws" *WAMJ* 7(3), 1933, p.96; C. Wilson, "The Treatment of Yaws with Acetylarsan" *WAMJ* 9 (2), 1937, p. 28; J.H. Youray, "Typhoid Fever" *WAMJ*, 6 (1) 1932, pp.11-13; F. I. Iweze, "Malaria" *Dokita, 1 (3), 1962, p. 10; E.C. Smith, "A case of Malaria with a Blood Picture" WAMJ*,5 (4), 1932, p.69; A.C. Patterson, "Report on the Treatment of Malaria by Atebrin and Plasmochin Simplex", *WAMJ*, 6 (4), 1932, pp. 68-70; J.A.K. Brown, "Problem of Treatment and Control of Leprosy", *WAMJ*, IX, (1), 1936, p. 10-14; T.C.G. Mayer, "The Distribution of Leprosy in Nigeria with Special Reference to the Aetiological Factors" part 1, *WAMJ*, 4 (1) 1930, pp. 12-14, Part II, *WAMJ*, 4 (2), 1930, pp. 23-25.

31. H.B. Lee, "Some Aspects of Medical Management in Nigeria" *WAMJ*, New Series VIII (1), 1932, pp.22-23.

32. J. Adeniyi, "The Role of the Hospital in Public Health Programme with Particular Reference to Developing Countries" *WAMJ*, New Series, VIII (1), 1958, pp. 73-77.

33. U. Beier, "Quack Doctors in Yoruba village" *Dokita* 1 (1), 1960, pp.57-58; U. Nwokolo, "The Practice of Medicine by Laymen in Nigeria" *Dokita* 1 (1), 1960, pp. 50-52.

been selectively accepted by many Nigerians. A new breed of practitioners who used partial understanding of Western medicine to exploit a popular demand for certain aspects of it had emerged. Some scholars labelled them quacks and charlatans. On the other hand their activities represented an index of indigenous response to modern medicine.

Medical policies also created a debate on existing practices. G.M. Bull (1960) criticised the practice in the Eastern and Western regions where greater emphasis was laid on curative medicine than preventive medicine and suggested that, at least, two-thirds of medical budgets should be devoted to preventive medicine.[34] Similarly, Samuel Manuwa, in 1961, condemned the lack of coordination between Federal and Regional Health Services and recommended the inauguration of a Nigerian National Health Council comprising federal and regional representatives.[35]

In addition to these categories of works there are other studies that provide scattered evidence relevant to an understanding of the development of modern medicine in Nigeria as well as the problem of implementation of medical policy. O. Ikime discussed the medical work of the Church Missionary Society at Bethel in 1930 and that of the Roman Catholic Mission in 1958 in his study of the Isoko people.[36] In

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34. G.M. Bull, "Impressions of a Medical Tour of Eastern and Western Regions of Nigeria" *WAMJ*,, IX (10), 1960, pp. 140-141.

35. S. Manuwa, "The Principles and Methodology of Planning the Development of National Health Programmes in Underdeveloped Countries", *WAMJ*, X (1), 1961, p.83.

36. O. Ikime, *The Isoko People*, p. 78

his other studies in Kwale-Aboh and Western Ijo divisions he also mentioned medical activities in these areas.[37] From this review we can see that the existing body of work on the medical history of Nigeria does not offer an in depth analysis and assessment of the medical activities of the agencies that developed modern medicine in Nigeria. Nor does it examine the reactions of the Nigerian peoples to modern medicine and their contributions to the establishment of health institutions. Therefore, there is a need for more work on the history of modern medicine in Nigeria.

It also shows that hardly any work, apart from Ikime's, has been done in the area of study. This study aspires to fill these gaps. It shows how modern curative and preventive medical systems started with medical services to government establishments and later transformed to institutions catering for the general public. Among other policies, it elaborates and evaluates the two main government policies that determined the rate and pattern of development in Nigeria and their implementation in the Warri Province: (1) The Towns and Police and Public Health Ordinance Number 10 of 1878 which restricted direct government medical and health activities to townships. It lasted till 1944; (2). The Colonial Development and Welfare Scheme of 1945 and its Revised Plan of 1951 which intensified and extended

37. O. Ikime, "Native Administration in Kwale-Aboh Division 1928-1950; A Case Study, *JHSN*, 3 (4), 1967, pp. 678-680; O. Ikime, "Western Ijo 1900-1950: A Preliminary Historical Survey" *JHSN* 4 (1), 1967, p. 83.

government medical services to the rural communities.[38]

It reviews government and missionary medical activities as well as the medical work of local governments, regional government, communities, individuals and companies. It examines the evolution of types of diagnosis and treatment for some endemic diseases especially yaws, smallpox, malaria and leprosy in a historical setting following discoveries of new drugs and methods rather than the scientific aspects of disease and research. It also examines the problems of the medical department and general administration in the Warri Province. But more importantly it investigates the acceptance or rejection of various aspects of modern medicine over time, by the Delta peoples and their contributions to the establishment of modern medical institutions in their communities.

Scope of Study.

The study covers the period 1906 to 1960. 1906 marked the beginning of institutional practice of modern medicine in the Warri Province. In that year the colonial government opened five hospitals in the coastal towns: Sapele, Warri and Forcados.[39] The study terminates in 1960, the year the colonial administration that

38. "The Towns and Police and Public Health Ordinance Numer 10 of 1878, *Laws of Colony of Lagos vol.I* (London: Stevens and Sons, 1902), pp.192-213; *A Ten-Year Plan of Development and Welfare for Nigeria: Paper Laid on the Table of the Legislative Council on the 13th December 1945 as Sessional Paper No. 24 as Amended and Approved by the Legislative Council on 7th February, 1946* (Lagos: Government Printer, 1946); *A Revised Plan of Development and Welfare Nigeria 1951-56; Paper Laid on the Table of the Legislative Council as Sessional Paper, No.6 of 1951* (Lagos: Government Printer, 1951).

39. NAI, Annual Report, the Colony of Southern Nigeria, 1906, pp. 331, 339, and 348.

superintended all health and medical activities came to an end. It is restricted to one of Nigeria's provinces, the Warri/Delta Province, so as to make it possible to have a deeper insight into the evolution of health and medical services. Developments in a province exemplified developments in the country because the province represented the largest political unit, from the beginning, in which national policies were implemented. Only slight differences resulting from local conditions could exist in various provinces.

The Warri Province, with headquarters at Warri, was created in 1914 along with other provinces after the unification of the Southern and Northern protectorates.[40] Before 1914, the area constituted a part of the Western Division with headquarters at Warri from 1900 and from 1906 a part of the Central Province also with headquarters at Warri.[41]

The provincial authorities initially organised the province into Kwale and Warri Divisions and subdivided the Warri Division into Sapele, Warri, Forcados and Ase sub-districts.[42] After December 1, 1932 they re-organised the province into Western Ijo, Jekri-Sobo, Sobo and Aboh Divisions because of a new policy which

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40. L.C. Gwam, "Administrative Changes in the Evolution of the Benin Province 1897-1956" *An Inventory of the Administrative Records Assembled from Benin Province,* (NP. ND) p.9.

41. *Ibid.*, pp. 5-8.

42. NAI, CSO 26/2/11857, vol. IX: Annual Report, Warri Province, 1931, p.1

emphasised the ethnic affiliations of the people as a criterion for grouping them into divisions.[43]

The name of the province was changed from Warri to Delta in 1952, as a result of a political conflict between the Itsekiri and other Delta peoples about the implication of the *Olu* of the Itsekiri assuming the title *"Olu* of Warri". The other ethnic groups conjectured, rightly or wrongly, that it might mean that they would also come under the suzerainty of the Itsekiri monarch especially as he moved his palace from Ode-Itsekiri to the provincial headquarters.[44]

The area covered by the Warri/Delta province lies between Latitudes 4° 21' and 6° 10' North and Longitudes 5° 20' and 6° 41' East. It is bound on the North by the Benin Province, on the South and West by the Atlantic Ocean and on the North-West by the Ondo Division.[45] The province had an area of 6,440 square miles inhabited mainly by the Aboh, Ijo, Isoko, Itsekiri, Ukwuani and Urhobo peoples.[46] Its population in 1952 amounted to 490,000.[47]

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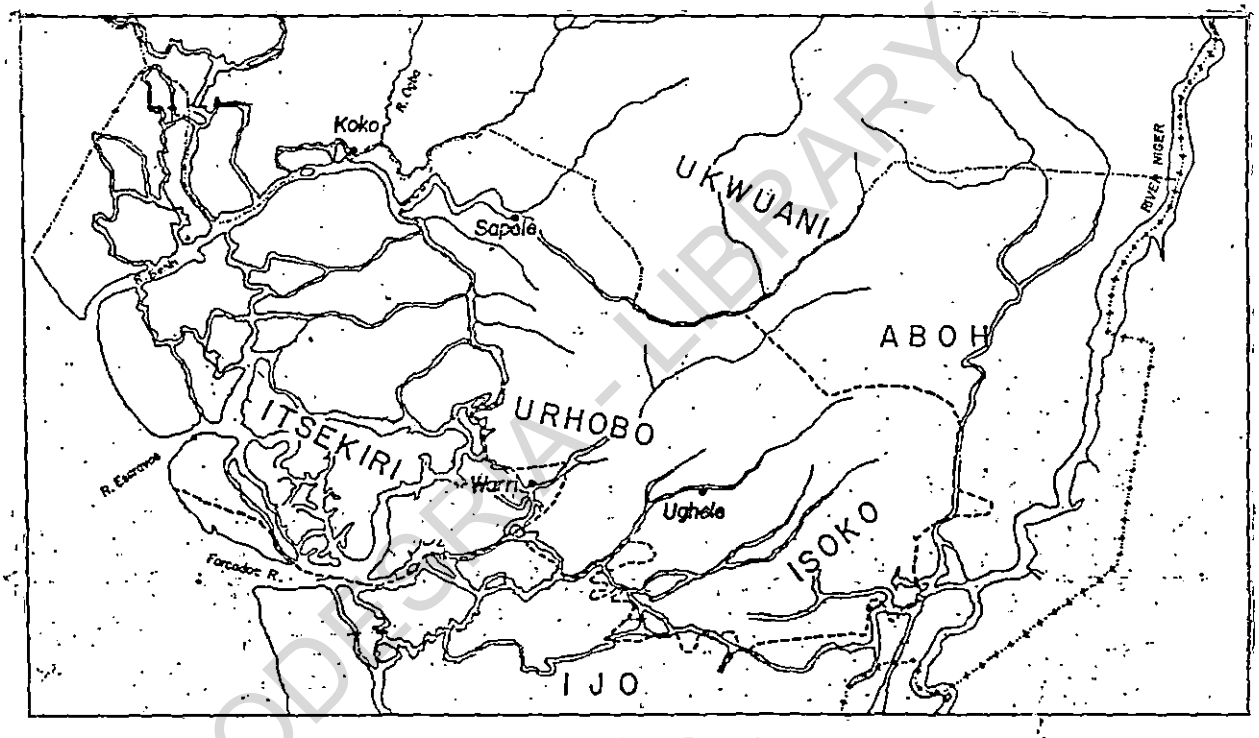
43. NAI, CSO 26/2/11857, vol. X: Annual Report, Warri Province, 1932, pp.17 and 18: O. Ikime, *Niger Delta Rivalry: Itsekiri-Urhobo Relations and the European Presence 1884-1936* (London: Longman, 1969), pp. 220-262.

44. NAI, CSO 26/2/11857/SI: Annual Report, Warri Province, 1952, p.1.

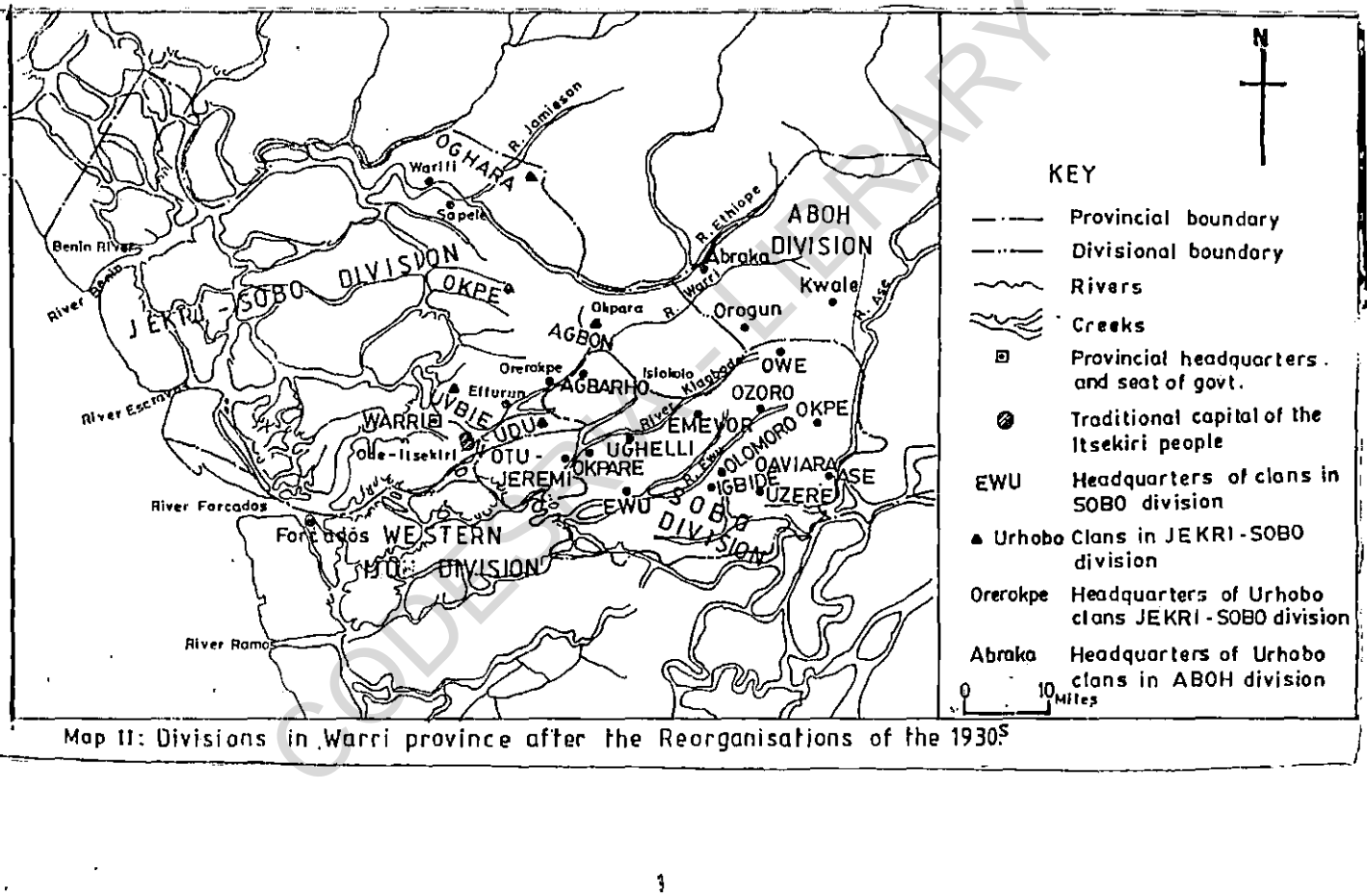
45. Annual Report, Warri Province, 1932, p.1

46. O. Ikime, "The Peoples and Kingdoms of the Delta Province" in *GroundWork of Nigerian History,* O. Ikime (ed.) (Ibadan: Heinemann Educational Books, 1980), p. 87.

47. NAI, MH/Fed/1/1/12616C: Annual Medical Report, Nigeria, 1st. April -31st December, 1954, p.11.



Map. I: Ethnic Groups in the Warri / Delta Province



Map II: Divisions in Warri province after the Reorganisations of the 1930s

Sources and Methodology

Information for this study was derived mainly from primary sources: archival records, government publications, Newspapers, mission papers and oral evidence. The limited relevant secondary sources were also used.

At the National Archives, Ibadan, there are numerous files relevant to this study. These include the records of the following offices and departments:

(1) Federal documents comprising the Chief Secretary's office papers and the Federal Ministry of Health papers;

(2) Warri/Delta provincial papers;

(3) Divisional papers of the Ughelli, Kwale, Sapele and Western Ijaw Divisions;

(4) Mission papers of the Benin Diocese of the Roman Catholic Mission.

Papers of the West African (Sierra Leone) Mission covering the years 1803 to 1914 and miscellaneous mission papers titled *Intelligencer* are also available in the K.O. Dike Memorial Library, University of Ibadan. These documents provide necessary information on the implementation of the health policies of the different levels of government and the missions in the province as well as the contributions and reactions of the Delta peoples to medical and health programmes.

Available government publications such as blue books, gazettes, policy papers, departmental orders, white papers and special reports on diseases and various health schemes provide all necessary information on policy formation and implementation. They also supply information on hospital statistics on staff, patients and diseases treated as well as control of particular diseases. Statistics is invaluable in assessing the people's response to various aspects of health policy. These relevant documents are listed in the bibliography.

Newspapers constitute another important source for the reconstruction of the medical history of the Delta peoples. The newspapers which were based in the Warri Province between 1935 and 1952: the *West African Star* (1935-37), the *Southern Nigerian Defender* (1944-45), the *Nigerian Standard* (1950), and the *Nigerian Star* (1950-1952), give insight into the state of public opinion on the policy and implementation of government and missionary health programmes. More importantly they highlight the contributions of the communities towards health programmes and amplify the reactions of the Delta peoples to modern methods of treatment. The views of the newspaper editors as well as those of the politicians and other Western educated citizens on various health and medical issues are documented in the text.

As the period of study is recent, extensive use of oral data was made to augment and corroborate official views especially as many of the chief actors in the various fields of health care are still living. There are, however, cases where people who participated directly in the health activities of modern or traditional medical practice are either few or extinct. In such cases their immediate descendants or junior ones in the profession were interviewed. This fact explains why persons below the age of fifty were interviewed. Conventionally, the evidence supplied by children or junior relatives constitutes valid sources of oral history, particularly in cases where they might have served as an apprentice to a deceased parent or relative. The interviews conducted between 1990 and 1995 involved the following categories of people: medical doctors, nurses, midwives, chief pharmacy technicians (dispensers), environmental health officers (sanitary inspectors), other civil servants with relevant experience, traditional healers and birth attendants, patients, politicians, old mothers, Christian priests and church elders, *Igbe* priests and priestesses. A total of fifty

recorded interviews were conducted. The transcripts will be submitted to the Department along with the thesis.

I employed mainly the formal technique of oral data collection. Questions that were meant to elicit all relevant information from the informants were drawn beforehand and directed to individuals or groups believed to be knowledgeable in various aspects of health care. All informants in one category answered the same questions so as to make it possible to assess and cross-check their testimonies. I recorded their responses immediately and did the assessment and analysis later. I also employed the informal technique of oral data collection on some occasions. As a resident in the area of study, I visited and observed some relevant scenes such as the celebrations of the Abraka *Ovwuvwu* annual festival and asked questions during conversations which aimed at illuminating my understanding of the procedures and the objectives behind them. Whatever I considered relevant was recorded later.

As has been shown in the literature review, only Ikime's articles and books provide some information, (and this is limited) on the medical history of the Warri/Delta Province while articles by medical officers give information on the incidence, aetiology and the research results on the cure of various tropical diseases in West Africa. These and the primary sources discussed above have supplied adequate information for the reconstruction of the medical history of the peoples of the Western Niger Delta.

In the reconstruction of the medical history of the Western Niger Delta peoples (Warri/Delta Province), I employed mainly the analytical method and critically examined the policies of the governments and the missions that determined the development of modern medicine, their implementation and factors affecting

acceptance of modern treatments by the peoples. Chronological and descriptive methods were also used. As a process of development, the stages of development are identified and organised in the order they evolved whereas the process of development of the various themes in medical and health services are described.

Organisation

The study is organised into six chapters. The first chapter treats the practice of indigenous medicine as a background to the study. The attitude of the Delta peoples to modern medicine resulted partly from their inherent ideas about causes, cure, prevention and control of diseases. These formed the social context and base shaping their acceptance or rejection of modern ideas concerning disease, health and treatment. They are here delineated and analysed.

The second chapter covers the period 1906 to 1929 and deals with the initial establishment of hospitals and dispensaries in the townships by the colonial government. The administration also instituted Public Health measures in these towns in accordance with the provisions of the Town, Police and Public Health Ordinance Number 10 of 1878.[48]

The third chapter covers the period 1930 to 1944 and focuses on the medical and health activities of the Christian missions and the NAs. These agencies initiated and dominated medical and health services in the rural communities till 1944 while the provincial and central authorities concentrated their services in the towns.[49]

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48. *Laws of Lagos vol.1,* pp. 383-389.

49. NAI, CSO 26/2/11857 vol. VIII: Annual Report, Warri Province, 1930, p.316; Annual Report, Warri Province, 1931, p.60.

The fourth chapter covers the period 1945-1951 and deals with the first phase of the colonial Development and Welfare Scheme. It was the first comprehensive plan of development for Nigeria and was jointly financed by the British government and the Nigerian administration. The scheme covered both urban and rural communities.[50]

The fifth chapter deals with the period 1951 to 1960 and centres on the Revised Plan of the Colonial Development and Welfare Scheme.[51] The administration decided to revise the Ten Year Plan because it achieved very little success in its implementation after five years. Unlike the original plan the regional governments drew and executed the Revised Plan. The new plan also introduced a new system of grants-in-aid to the Christian missions and the Native Administrations for their medical activities. Though originally meant to end in 1956, the execution of the Revised Plan for health services continued till 1960 because a new national plan inaugurated in 1955 did not introduce new health programmes. It emphasized completion and consolidation of old health programmes.[52]

Chapter Six is the Conclusion. It summarises the conclusions concerning the development of modern medicine and the reactions of the Delta people to it. It also highlights the new perceptions of the people about health, disease and treatment.

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50. *A Ten-Year Plan of Development for Nigeria;* p.68

51. *A Revised Plan of Development and Welfare Nigeria,* 1951-56, p.3

52. NAI, Ughel Dist.1/1727; New Five Year Development Plan 1955-1960, p.1

CHAPTER ONE

TRADITIONAL MEDICAL PRACTICE AMONG THE DELTA PEOPLES

Introduction

Before the advent of modern medicine, the Delta peoples (the Aboh, Ijo, Isoko, Itsekiri, Urhobo and Ukwuani), had developed a medical culture which they considered very effective in diagnosing, curing and preventing diseases. The importance they attached to the restoration of health to the sick also motivated their appreciation of modern medicine and their contributions to its development. They welcomed modern medicine not, however, as a substitute for traditional medicine but as an alternative method of treatment. Hence, throughout the colonial period, most Delta peoples remained attached to indigenous medical practices to solve their basic health problems. They also relied on modern medicine for the management of other health problems. Their choice usually favoured the system they considered more effective in handling any particular case of ill-health. To appreciate this syncretic approach to health management after the introduction of modern medicine, it is necessary to survey their traditional medical culture. This chapter aims to delineate their beliefs about causation, cure, prevention and control of diseases as well as their process of healing, the functions of medicine and specialists in the practice of indigenous medicine as a background to this study.

Indigenous Medical Practices of the Delta Peoples

The distinct polities inhabiting the Warri Province developed similar socio-economic and political organisations which resulted in the development of common beliefs concerning causation, cure and prevention of diseases long before the imposition of colonial rule. A survey of these organisations will aid our understanding of the common medical culture that developed among them. The Aboh, the Itsekiri and some Urhobo and Isoko clans developed kingship institutions at different times in the evolution of their political system. While the Itsekiri and the Aboh represented the earliest kingdoms, some Urhobo and Isoko clans developed monarchical institutions later. Some of the Urhobo and Isoko kings (ivie) such as the Orodje of Okpe, the *ivie* of Agbon, Ughelle and Ewu combined executive and priestly functions in a similar manner as the Olu of Itsekiri and Obi of Aboh, whereas other *ivie* functioned only as chief priests of their clans. At the local level, all the Delta peoples had village organisations. Except for the Itsekiri, others had age sets, at this level, which performed specific social and political functions with the elders constituting the ruling body.[1]

Their religious beliefs often coincided, differing only in terminologies, details and duties assigned to the religious functionaries. They all believed in the existence of the Almighty God, divinities, ancestors, evil spirits, witchcraft and sorcery. These religious beliefs greatly influenced their medical culture as they featured prominently in the causation, cure and prevention of diseases. The

1. O. Ikime, *Niger Delta Rivalry: Itsekiri Urhobo Relations and the European Presence* 1884-1936 (London: Longman, 1977), pp. 96-101; NAI, CSO 26/27992: Intelligence Report, Aviara Clan Isoko, 1932, p.13.

various vernacular names of these supernatural forces and other terms relevant to this study are tabulated in table one below.

Table 1

Vernacular Names of Religious and Medical Terms of Various Delta Ethnic Groups

	English	Ahoh/Kwale	Ijo	Isoko	Itsekiri	Urhobo
1	God	Chuku	Tamarou	Oghene	Oritse	Oghene
2	Ancestor	Ndi-Chie	Orusereotu	Osomo	Ebura	Erivwi, Esemo
3	Divinity	Efa	Oru	Edho	Umale, Osa	Orha
4	Witchcraft	Ogbome	Diriguo	Eda	Oso	Orha
5	Witch	Ogbome	Diriguoere	Orieda aye	Oloso, Olobiren	Orieda
6	Wizard	Ogbome	Diriguowei	Orieda Ozone	Oloso Olokeren	Adjele
7	Coven	Ubom	Agbonbou	Ogbeda	Uja	Egben
8	Witchcraft-antidote	Ogu Ogbome	Diriscimo Keneogbanu	- 1	Irawo Oloso	Ekpofia
9	Age grade	Otu	Otu	Oribe	- 2	Edje
10	Diviner	Ogbu-ebunu	Eyebiowei	obo	Ewo	Obuepha
11	Priest	Ogonmor	Orukareowei	Ozere	Okpanran	Orheren
12	Medicineman	Dibie	Donzuwoirei	Obo	Olirawo	Obo
13	Sacrifice	Ese	Ekenya	Idhe	Osen	Izobo
14	Midwifery	ine Omumu	Erezimo	Eye	Ogbubi	Orhere
15	Midwife	One Omumu	Erezimoere	Oye	Ogbubi	Orhere
16	Psychiatry	Ela	Nomo	Osiwirue	Ewo Olubomeji	Osivwerhue
17	Orthopedics	Igba-Okpukpu	Emgboudon	Enwa	Ewo Esu	Oboribeku
18	Surgery	Iwa Ife	- 3	- 4	Osen	Ebere
19	Medicine	Ogu	Diri	Umu	Irawo	Uhurwu
20	Disease	Emo	Don	Emiavwe	Ukobo	Emiavwe
21	Evil Spirit	Ejonmor	Seiteme	Ezi Ogbegbe	Emiesu	Erhimuemi

- 1 Not known

- 2 - 4 Could not translate

Translated by (1) John Denedo (Urhobo) (2) Jackson Ireyefoju (Itsekiri) (3) J.P. Omobude (Isoko) (4) J.A. Baro (Ijo) (5) P.O. Abamba (Aboh/Kwale)

Similarities in the socio-political organisations, as well as the diagnostic and therapeutic traditions of the Delta peoples, resulted from a number of factors. First, they share common boundaries and had developed social and economic linkages through inter-marriage and trade for centuries. The riverine communities, mostly the Ijo, Itsekiri, Aboh and some Isoko, produced fish and salt which they exchanged for agricultural produce such as yams, palmoil and cassava from the hinterland peoples: the Ukwuani, Urhobo and some Isoko.[2] Moreover, nationals of these respective groups had settled together in the same communities even before such communities attained township status. For example, Urhobo communities (Okere and Agbassah), Ijo communities (Ogbe Ijo), and itsekiri communities had settled together in Warri long before European contact.[3] Itsekiri settlements stretched along the main waterways of the province bordering on the Urhobo clans of Okpe, Oghara, Agbon, Udu, Jeremi, Uvbie and Ijo clan of Gbaramutu.[4] Furthermore, some village groups in the Delta Province comprised peoples of different extraction. The District Officer, Percy Victor Main observed in the Igbuku, Ibrede and Anyama-Awa village groups that:

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2. Ikime, pp.30-31.

3. J.O.S. Ayomike, *A History of Warri* (Benin City: Ilupeju Press, 1988), pp.58-61.

4. NAI, CSO 26/27675: Intelligence Report, Jekri Subtribe, 1932, pp.5 and 13.

> Each village-group represents a hotch-pot of Aboh and Sobo settlers, but it must be accepted as a principle that the land on which they are situated originally formed part of the Aboh State.[5]

Secondly, the traditions of origin of most Delta kingdoms and clans point to Benin as their original home. Some Ijo clans, however, trace their origin to the Eastern and Central Delta, while a few Urhobo clans trace their origin to Ijo, whereas some Isoko clans claim origin from the Eastern Igbos. Obaro Ikime has established strong Benin influence on the socio-political institutions of some of the Delta polities. He, however, saw the possibility of Benin influence resulting in the claims of Benin origin by some groups because of the desire to identify with an influential power.[6] An alternative interpretation might be that Benin influence validates the claims of Benin origin. If this is correct, then it helps us to explain the similarities in the socio-political structure of the Delta groups that had a common origin.

Within this socio-political and economic context, indigenous medical practice encouraged medical practitioners to settle in other lands temporarily or permanently to practise, recruit and train apprentices as well as to expand their knowledge of local medicinal lore. Such constant interaction and compact settlements facilitated diffusion of therapeutic methods among the Delta peoples.[7]

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5. NAI, CSO 26/28903: Intelligence Report, Aboh-Sobo Village groups, 1933, p.2.

6. O. Ikime, "The Peoples and Kingdoms of the Delta Province", in *Ground Work of Nigerian History,* ed. O. Ikime (Ibadan: Heinemann Educational Books, 1980) pp. 89-96.

7. Interview, David Enaworu, Herbalist and witch doctor, Aged 55, Abraka but hails from Okpara in Agbon Clan, 15 November, 1990, 28 January, 1991.

Beliefs about Disease Causation

All Delta peoples believed that diseases resulted from either natural, metaphysical or spiritual causes. They believed that such natural phenomena as overwork, consuming bad food or water, over-feeding or under-feeding, worms, insect or animal bites, dirty surroundings, sexual contact, alcoholism, accidents, exposure to excessive heat or cold, emotional disorder resulting from misfortune and disaster caused infirmity.[8] Diseases attributed to natural causation included: malaria, headache, yellow fever, measles, cold, jaundice, yaws, sore, ulcers, cough, tuberculosis, convulsion, dizziness, ringworm, itching, stomach ache, constipation, indigestion, diarrhoea, dysentery, pneumonia, elephantiasis, earache, eye troubles, asthma, respiratory complaints, snake and human bites, impotence in men, stroke, eczema, chest pains, menstrual pains, nose bleeding, vomiting, gonorrhoea, sleeping sickness, piles, madness and dumbness.[9]

Sometimes the Delta peoples ascribed these very diseases to metaphysical or spiritual forces such as the divinities, ancestors, witches, wizards and sorcerers. All villages, clans and kingdoms had divinities or gods endowed with distinct functions. Each divinity had a shrine and a priest or priestess who offered sacrifices and performed rituals to it. At each level of social organisation and government

8. Interview, Johnson Eyekpeha, Herbalist and Midwife, Aged 70, Urhoka, 22 November, 1990.

9. J.O. Ubrurhe, "Urhobo Traditional Medicine", Ph.D. Thesis, Department of Religion, University of Nigeria Nsukka, 1993, pp.215-232; and Interview, A. Edigbe, Herbalist, Aged 89, Urhuvie, 10 September, 1991.

(village, clan, and kingdom), priests and priestesses constituted important personages, respected because of their position as inter-mediaries between the people and the gods; except among the Itsekiri where most priests were slaves whose inferior social status detracted from their prestige. Most priests represented an important component of the political elite as they combined priestly and political functions.[10]

Early explorers, missionaries and administrators referred to these divinities and their shrines as juju, idols and fetishes. According to Percy Amoury Talbot they:

> Include, in ordinary parlance, not only the minor gods and spirits and their symbols but also the elementals, as well as the powers created by magic.[11]

In the Aboh kingdom William Allen and T.R.H. Thomson remarked that:

> The religious superstitions of Aboh are as various and degrading as at any place we visited, and the fetiches, or idols, as numerous; every hut having one or more, as well as amulets or charms, suspended from sticks in the quadrangular courts.[12]

W.A. Moore simply observed that, the Itsekiri was originally a pagan and even at that moment his belief in many gods still possessed him.[13] To the precolonial

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10. NAI, CSO 26/27992: Intelligence Report, Aviara Clan Isoko, 1932, p.13; CSO 26/27998: Intelligence Report, Evweremi clan Urhobo, 1931, pp.24-25; CSO 26/29182: Intelligence Report, Benin clan, Ijaw, 1930, p.23; CSO 26/27918: Intelligence Report, Ossissa village group Kwale, 1932, pp.23-24.

11. P.A. Talbot, *The Peoples of Southern Nigerian* vol.II, (London: Oxford University Press, 1926), p.79.

12. W. Allen and T.R.H. Thomson, *Trotter's Expedition to River Niger,* vol.I, (London: Frank Cass and Co., 1948), p.242.

13. W.A. Moore, *History of Itsekiri* (London: Frank Cass and Co., 1970), p.210.

Delta person these gods and their paraphernalia represented reality and belief in them influenced his or her life greatly. The most relevant divinity to our study is, however, the fertility and ethical divinity. Among the Urhobo, M.Y. Nabofa has noted that they are believed not to condone falsehood, stealing, misappropriation, oppression, bewitching and adultery.[14]

Transgression against ethical divinities attracted punishment in the form of disaster, misfortunes and disease. The Delta people saw them as a major cause of disease. Hence, Talbot described them as "policemen who detect(ed) wrong doings as well as the judge who punish(ed) it"(sic)[15]

According to the various Delta peoples, the ancestors also constituted other guardians of the communities' morality and laws believed to punish deviants with disaster and disease. The belief that husbands and children could suffer infirmities because of the sins of their wives and mothers led to the practice of indoctrinating new wives into the cult of ancestors in their husbands community, so that they could be sanctioned and protected. G.T. Basden's observation about the Niger Igbos that often women confessed being the cause of their husband's illness if they committed adultery also applied to other Delta people.[16]

The Delta peoples also believed that witches, wizards and evil spirits afflicted innocent people who might be their enemies or rivals. In each village,

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14. M.Y. Nabofa, "A Survey of Urhobo Traditional Religion" in *The Urhobo People* ed. Onigu Otite (Ibadan: Heinemann Educational Books, 1982), pp.223-224.

15. Talbot, p.7

16. G.T. Basden, *Niger Ibos* (London: Seeley Services and Co.,1966), p.66.

clan or kingdom trials by ordeal and sanctions existed for those accused of, or proved to be witches or wizards. In pre-colonial times, witchcraft constituted a serious crime among all Delta peoples for which punishment ranged from burying alive to hanging or burning.[17] The ethical divinities of each village, clan, or kingdom also detected and punished witches and wizards. The most popular in the pre-colonial period was the *Eni* cult of the Uzere clan about which Obaro Ikime commented thus:

> Eni was the clan god inhabiting a lake named after it. It is not now known when it was first recognised that Eni could detect and at the same time kill off witches. By the middle of 19th century, however, it is said that hundreds of suspected witches were taken to Uzere every year.
>
> To Eni came not only the Isoko and Urhobo, but also Ijo, Itsekiri, Kwale and Aboh.[18]

The fear people held for witchcraft emanated from their belief that the practitioners could cause all known human diseases, accidents and misfortune. For the same reason people feared evil-spirits, believed to be spirits of people who died mysteriously and were not accorded appropriate funeral rites.

Because of these powers and functions ascribed to these metaphysical forces the people could impute an illness to a natural cause or to any of these forces. For example, the Delta people could attribute a woman's protracted labour to a supernatural cause due to infidelity calling for the remedy of confession of her

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17. NAI, CSO 26/29183: Intelligence Report, Ogunla Clan Ijaw, 1930, p.6; CSO/26/27918: Intelligence Report, Ossissa Clan Kwale, 1932, p.33; CSO 26/27991: Intelligence Report, Okpe Clan (Urhobo), 1932, p.52); Talbot, pp.207-209.

18. Ikime, *Niger Delta Rivalry*, pp.37-38.

guilt, or the malevolent act of a witch who "locked the baby in the womb". Even when the actual physical conditions such as the size of the baby vis-a-vis the birth canal through which it passed and weakness in the mother were obvious. Nevertheless, the traditional healers claimed competence to cure all known ailments no matter the nature of their causes. Whereas the herbalists could treat diseases of natural causation with herbs and other methods of therapy, they required the assistance of diviners for diagnosis, and priests for appeasing the supernatural forces when they treated diseases of metaphysical causation.

Even ordinary citizens acquired knowledge of treating some common ailments to minimise the rate at which they consulted professional healers. This practice continued even after the introduction of modern medicine. Even to-day many parents still treat minor ailments with traditional medicine. For example, a concoction produced by boiling mango, lime, pawpaw and guava leaves together constitutes a common, and often efficacious treatment for malaria, if taken twice a day. The patient should also bathe with the concoction. Pounded and boiled bark of an oilbeantree (*Okpagha Urhobo*) provides a decoction for the treatment of ulcers and sores when applied directly on them.[19] Covering the nose with ground or squeezed charcoal stops nose bleeding while latex squeezed out from fresh *Asakrasa* (Urhobo) leaves is adequate first-aid treatment for fresh wounds. Diarrhoea and dysentery stop after washing the patient's legs from the knee to the toes with water in which the leaves of *Ijiro* (Urhobo) plant are

19. Ubrurhe, pp.215-222.

squeezed while the patients face the sun.[20] It is only when complications set in that the necessity arises for professional treatment by traditional healers or practitioners of modern medicine.

After the introduction of modern medicine the Delta peoples also acquired knowledge of the use of English drugs and expanded their repertoire of home remedies. They first tried to treat minor ailments such as headache, cuts, malaria, vomiting and pains with drugs bought from medicine stores and consulted medical institutions if they failed. This practice created an environment for ready acceptance of modern medicine because of the popularity of patient medicine dealers and stores. This popularity continued beyond our period of study. It demonstrated that modern medicine was easily assimilated into indigenous medical practice.

Indigenous Healing Process

The process of healing any disease depended on what the healer believed to be its cause. Diseases of natural causation readily responded to ordinary treatment with herbs or other therapeutic methods. Diseases of supernatural causation, however, required divination as a means of diagnosis, often accompanied by appropriate sacrifices, through the officiating priests and priestesses, to reconcile the patient with the aggrieved supernatural forces before any healing method could be effective.

Unless the sick person suspected metaphysical causation of his or her ailment, he or she did not consult a diviner beforehand, but consulted a medicine

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20. Interview, Enaworu.

man or woman of his or her family's choice, to whom he or she disclosed, in confidence, the symptoms of the illness. The medicine man or woman interrogated him or her and palpitated the afflicted parts of the body to know the nature of the malady. The initial treatments usually aimed to relieve the pains, but in some cases they might seek deliberately to aggravate the symptoms in order to facilitate diagnosis. At this stage the healer's treatments depended on the symptoms, on the assumption that the ailment had a natural cause. If it continued to defy treatment, he or the patient would investigate other possible causes through a diviner.[21]

A diviner is a specialist whose main function was (and is) to unveil the supernatural cause of a patient's illness. G.T. Basden defines such a specialist as "a worker with charms whereby the spirits foretell the future and give directions for procedure in the matter of sacrifices."[22] This definition would apply to various diviners in the Delta. For the cure of diseases, the diviners prescribed the type of sacrifices, the required items and, in some cases, designated the particular practitioners who could effect the healing. Some herbalists performed a dual role and so acted as diviners or priests and could therefore direct the whole process. Divination therefore constituted a holistic diagnostic system for diseases believed to have unnatural causes. The divination process involved throwing a set of spiritually charged objects (cowries, kolanuts, calabashes), "reading" them, and

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21. *Ibid*; Interview, Edigbe.

22. Basden, p.55

interpreting the patterns in which the objects lay in relation to another.[23] Usually the patients and their relatives carried out the prescriptions of the diviners for sacrifices to ensure their effectiveness.

The Delta peoples, believed that sacrifices acted as effective means of appeasing the supernatural forces believed to be responsible for an illness. The patient supplied the sacrificial items prescribed by the diviner. The high priest or priestess of the identified divinity officiated at the required ritual while family elders officiated in sacrifices to the ancestors or an ancestor. A witch or wizard, interceding on behalf of a patient offered sacrifices to witches or wizards.[24]

Belief in the efficacy of divination and sacrifices has persisted among the Delta peoples and has remained a factor in health care long after the introduction of modern medicine. Therefore they sometimes employed the services of diviners and sacrificers in treating diseases they believed to have emanated from metaphysical forces, especially as modern medicine did not provide alternative treatment for them. On the other hand, they readily accepted modern treatment for diseases they believed to have resulted from natural causes and for which modern medicine proved very effective. Moreover, such modern methods as surgical operations and blood transfusion impressed and attracted the Delta people.

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23. D.T. Okpako, "Culture and the Development of Medicine" in *Nigeria since Independence: The First Twenty-five Years,* vol.II, Culture (eds.) P.P. Eke and Garba Ashiwaju (Ibadan: Heinemann Educational Books, 1989), p.228.

24. Interview, Enaworu.

Therapeutic Methods

Herbal treatment constituted the most common method of therapy. Even in the Western world, practitioners of holistic medicine believe in the efficacy of herbs because they contain natural nutrients needed by the body for its sustenance and therefore help in correcting nutritional deficiencies.[25] A mixture of herbs, roots, bark, leaves and other ingredients such as animal parts and chalk constituted a herbal preparation. Every herbalist therefore knew the qualities of herbs, their healing powers and functions as well as the most effective combinations of the *materia medica* for each disease he treated.

In the Delta, herbal preparations often required prayers and incantations to become effective. The herbalist usually solicited the help of God, a divinity, his ancestors and his mentors, living or dead, in the art of healing. He or she prayed that these forces would intercede to ensure that his or her concoctions, whether perfectly or inaccurately prepared, acted effectively to neutralise any other potent herbal preparations applied by a hostile or malevolent native doctor.[26] He then tasted the medicine before handing it to the patient with necessary instructions, thus demonstrating its safety and purity.[27]

Other therapeutic methods included hydrotherapy, cupping, surgery, heating and massaging. Hydrotherapy included poultices, hot or cold bath as well

25. J.O. Mume, *Traditional Medicine in Nigeria,* (Benin City: MNC, 1973), p.95

26. Nabofa, p. 227; and Interview, Eyekpeha.

27. Interview, Eyekpeha.

as inhaling hot steam.[28] It warmed or cooled the body, aided digestion, increased the activity of the perspiratory glands and facilitated the elimination of broken down tissue cells and poisonous matter.[29] Massaging consisted of squeezing, rubbing and pressing the skin muscles with bare hands. A method, first employed in Ijoland because of its riverine environment without herbs, to invigorate blood circulation, treat ailments of the nervous, muscular and osseous systems as well as gynaecological problems, spread to other Delta peoples later.[30] Traditional surgeons removed bullets and poisoned arrows and performed circumcisions. They also performed operations on the belly to remove diseased tissues. The *Oboroberihwo* (surgeon urhobo) did the stitching by "technical application of pieces of calabashes on the operated parts" and used traditional anaesthetic herbs to relieve pains.[31] Dry heat from a fire applied in several forms soothed the body cells and cured some other ailments.[32] Cupping involved draining impure blood from a part of the body through slight cuts, by sucking through a horn. It was commonly applied for treating rheumatism and abnormal swellings.[33] Several diseases required starving while others called for confession before applying other

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28. Mume, pp.54-56.
29. Ubrurhe, p. 163.
30. *Ibid.*, p. 162.
31. Mume, pp. 66-67.
32. *Ibid.*, pp.67-70.
33. Ubrurhe, p. 168.

methods.[34] Not infrequently the treatment of most diseases needed a combination of methods. Except for massaging, these other methods required the use of herbs. For example, boiled or soaked herbs went along with cold or hot baths meant for treatment.[35] The surgeons used herbal preparations to treat pains and wounds.[36]

Indigenous Preventive Medicine and Measures

The causes of diseases determined the nature of preventive measures or medicine against them. All Delta peoples believed that diseases of natural causation could be prevented by avoiding their known causes such as bad food or water, unhealthy surroundings, sexual contact, alcoholism and exposure to bad weather, among other things. For example, among the ethnic groups in the Warri Province, except for the Itsekiri, a particular age set or sets, the *Gegenkalawoma* (Ijo) or the *Emaha* (Isoko and Urhobo), undertook responsibility for keeping compounds and public place in the towns and villages, such as market places, streams and paths leading to them as well as public gathering grounds clean. Among the Ukwuani, three age sets shared these responsibilities. The *Otuaya* age set kept the compounds and wells clean, the *Otuonogbe* kept the entrance to the quarters and roads to farms clean, while the *Otuirre* took responsibility for the cleanliness of the open spaces including the dancing grounds and market places.

34. Mume, pp. 64-65.

35. *Ibid.*, p. 65.

36. *Ibid.*, p. 66

Among the Urhobo and Isoko as well, the *Ivrawa* age set also assisted the *Emaha* by clearing and cleaning inter-village roads and juju groves as well as supervising the sanitary work of the *Emaha* age set.[37] In pre-colonial times, among the Itsekiri, slaves performed these duties.[38] Throughout the colonial period the local administrators admired and encouraged their sanitary duties by instructing the sanitary inspectors and overseers to mobilise them while carrying out their duties. The District Officers and Residents in the province reported favourably on their complementary role in effecting sanitary duties.[39] For example, the District Officer Urhobo Division, John Charles Forbes Pender suggested, in 1938, that:

> It would be a great mistake to step in and assume the sanitary control of the villages. It would break down the native sanitary system whilst funds available would not be sufficient to replace it by an effective service such as outlined by the Senior Health Officer.[40]

This provided a good example of where colonial administrators appreciated indigenous methods and systems and encouraged their continuity. To prevent afflictions from the ancestors and the divinities the Delta peoples tried to

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37. Intelligence Reports, Okpe Clan Urhobo, pp.48 and 52; Ogunla Clan Ijaw, p.14; Aviara Clan Isoko, p.15; NAI, CSO 26/29300: Intelligence Report, Kwale Ibo Clans, 1932, p.25.

38. Interview, Jackson Ereyefoju, Aged 57, Lecturer, Delta State University, Abraka, 18 October, 1995.

39. NAI, CSO 26/2/11857 vol. VIII: Annual Report, Warri Province, 1930, p.29.

40. NAI, Ughel Dist 1/1297/1, p.8: Memo Ag. DHS to Residents 10.9.38.

avoid violating the communities' moral codes.[41] Parents and elders educated their children, spouses and strangers on the taboos of their community and the consequences of violating them.[42]

All Delta peoples strongly believed in preventive medicine against some physical and metaphysical attacks as well as against some insect and animal bites. Medicine men and women prepared charms, talismans and amulets to ward off the evil spells of malevolent spirits, sorcerers, witches and wizards. Preventive medicine also neutralised poisons introduced into food, drinks or any objects that the targeted victims could come into contact with. Antidotes against machete cuts and gunshots as well as against insect and animal bites also existed. Whereas people wore talismans, amulets and rings as physical symbols of immunity, some concoctions were buried in particular spots in the compounds, while others were suspended on roofs of houses. More importantly, the herbalists introduced some of the concoctions into the blood stream of the clients through slight cuts on the body especially the chest.[43] The earliest documented description of such practices was Allen's and Thomson's observation in the Aboh Kingdom during their 1841 expedition that every hut had idols, amulets or charms suspended from sticks.[44]

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41. Mume, p.37.

42. Nabofa, p.226.

43. Interviews, Edigbe, Enaworu and E.Aganbi, Herbalist, Aged 60, Onyobru Jesse, 27 October, 1991.

44. Allen and Thomson, p. 242.

Some of the objects they described consisted of medicines prepared to neutralise one form of attacks or the other from enemies. Introducing medicine into the blood stream during traditional innoculation corresponded with the modern process of immunisation against smallpox and injections. This similarity provides a possible reason for the popularity of vaccination and injections among the Delta peoples after their initial resilience.

As in the cure of diseases, persons seeking any type of immunity provided the items prescribed by the medicine man or woman who prepared the concoctions. After the preparations he or she blessed it before delivery to the client who was believed to be immune to the anticipated attacks by an enemy, on the condition of course, that he kept strictly to the 'doctors' instructions. Indigenous preventive medicine represented another branch of medical practice that modern medicine did not cover at all, except for inoculation against smallpox and other diseases. The Delta peoples therefore continued to consult their medicine men and women to immunise themselves against these forces and various human attacks.

Isolation also constituted another traditional method of preventing the spread of some diseases. Before the colonial period, sufferers of leprosy and smallpox remained isolated in their houses or were driven away to live in the bush because people believed that their diseases resulted from wrong deeds in the society.[45] Interaction with other members of the community could resume only

45. S. U. Erivwo, *Traditional Religion and Christianity in Nigeria: The Urhobo People* (Ekpoma: Department of Religious Studies and Philosophy, Bensu, 1991), p. 86.

after their recovery and performing all the necessary rituals and sacrifices. These measures helped to control the spread of these deadly infectious and contagious diseases. The popularity of the modern methods for the control of these diseases, especially leprosy, derived partly from employing a similar method of isolation.

The Delta peoples also believed that medicine promoted economic and social well-being and solved other human problems not directly related do health. The medicine men and women prepared medicines for promoting business, improving memory, checking thieves, winning court cases and attracting favour from others.[46] Again, modern medicine did not cover these aspects of traditional medical practice, hence the medicine men and women continued to be the only providers of such medicines to people desiring them.

Specialists in Indigenous Medical Practice

Every traditional medical practitioner had, according to his training or call, a special area of expertise. He or she, however, might be knowledgeable in other areas because he or she continued to learn the use of more herbs and new methods as long as he or she practised.[47] Such areas of specialisation among all Delta peoples included midwifery (*Orhere* Urhobo), psychiatry (Osivwerhue Urhobo), orthopedics (*Oboribeku* Urhobo), witchery (*orha* Urhobo), and surgery (*Ebere*

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46. J. O. Mume, "Tradomedicalism and Witchcraft" *Lecture Sponsored by the Institute of African Studies, University of Ibadan* (Ibadan: Ibadan University Press, 1984), p.7; Interview, B.J. Itsueli, Lecturer, Aged 56, Abraka, 24 February, 1993.

47. Interview, Eyekpeha; A. Adeloye, *The African Pioneers of Modern Medicine: Nigerian Doctors of the 19th Century* (Ibadan: Ibadan University Press, 1985), p.39.

Urhobo).[48] A midwife (*Orhere*), who could be male or female, took care of problems related to pregnancy and child delivery as well as various problems connected with menstruation and conception.[49] Most mothers in the Delta Province relied on the efficiency and competence of the traditional birth attendants that they often refused to give birth to their babies in colonial hospitals even though they readily accepted ante-and post-natal treatment in maternal and child-welfare clinics. More important, however, was the fact that some modern procedures strongly contradicted cultural beliefs and practices. Many Delta people also preferred the methods of treatment by indigenous psychiatrists. Their treatment of mental disorder called for beating and chaining to calm the patient. The Delta peoples believed their treatment to be more effective than Western psychiatric methods because they employed psychosomatic methods to unveil and treat the likely causes of each mental case.[50] Bone-setting was another traditional method widely believed to be more effective than modern treatment because the practitioners handled all cases of fractures effectively without resort to

48. Interviews, Isaac Ogbuthu, Traditional Healer, Aged 44, Ozoro, 26 November, 1991; Umukoro Ighomor, Traditional Healer, Aged 77, Erovie Ozoro, 2 December, 1991.

49. Interview, Victoria Ikoro, Traditional Midwife, Aged 49, Abraka, 17 January, 1993.

50. Mume, *Traditional Medicine in Nigeria,* pp. 86-87; A.E. Erinosho and A. Ayorinde, *Traditional Medicine in Nigeria: A Study Prepared for the Federal Ministry of Health* (Lagos: Government Printer, 1985), pp. 64 and 75: Interview, Enaworu.

amputation.[51] Witch doctors, former witches who confessed their sins, or active witches, treated diseases caused through witchcraft. Only themselves and diviners could reveal the cause of such diseases and the method for appeasing the aggrieved witch or wizard. In this area of medical practice Western medicine was conceived to be completely ineffective because it "treated only the symptoms of ailments" without removing the cause.[52]

Methods of Acquiring Knowledge of Traditional Medical Practice

In analysing the transfer of knowledge in indigenous medical practice we must rely on the life histories of present day herbalists. Their careers provide evidence that the indigenous health system delineated in the preceding sections still remains important in local health care and bears testimony to the link between the past and the present. Some traditional healers acquired the knowledge of their practice from members of their family. Certain families specialised in healing particular diseases and rarely divulged their specialised knowledge to people outside their family circles. For example, the Udi family in Okpara-Waterside has monopolised the art of bone-setting in Agbon clan since the 19th century. Osikagu Omakpokposi learnt the art from his slave when his son, Udi, had a complicated fracture. Before he died, he passed the expertise on to Udi and warned against passing the knowledge to any other family. Udi Osikagu taught his son Ejinavi Udi who in turn tutored his brother, Peter Udi, the incumbent healer. According to

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51. Ubrurhe, p. 311

52. Interview, Enaworu.

Peter, no case of fracture had come to them without being successfully treated.[53]

Other traditional healers claimed that they received their knowledge of medicine from the spirit world. According to Fidelis Awenagha, his father, Awenagha Akaruase, received the medicine for curing bites of the scorpion, dog, rat, cat and snakes from spirits in a dream. His father showed him the required herb. He has already taught his brother and they do not intend to extend the use of that herb to other people. At present no other person or family cures such bites within Abraka clan. Fidelis claims ability to cure fresh bites within a day while older ones can take up to three days to heal. According to him, he had successfully treated many people including the son of Dengo Ifeanyi who had a rat bite, after they had failed to get relief in a hospital.[54]

Like Awenagha the most popular traditional birth attendant today in the Abraka clan, Mrs. Lydia Abamba, who has been co-opted into the Primary Health Care Programme, claims to have received the medicines from spirits. According to her account, she received instructions about her calling after three encounters with a water spirit. While the first and third encounters occurred in a dream, the second involved a life experience in a river. According to her, the spirit revealed the duty assigned to her and the herbs to use, warning her not to refuse the call. She claimed to have assisted many mothers including Mrs. Ogberagba Okolie of Ekerejeta and Mrs. Otutu of Utagbaogbe who had their first babies in hospitals

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53. Interview, Peter Udi, Herbalist/Bone-setter, Aged 80, Okpara-Waterside, 25 April, 1995.

54. Interview, Fidelis Awenagha, Civil Servant/Herbalist, Aged 33, Abraka, 26 April, 1995.

through operation (caesarean section) to give birth to their subsequent babies normally.[55]

Apprenticeship, however, constituted the most common method of learning the art of traditional healing. Through mutual agreement the master healers trained interested people who could come from within or outside their families or ethnic groups. The period of apprenticeship varied from two to eight years, depending on the age of the apprentice and the range of healing methods he or she intended to acquire. At graduation he or she joined the association of traditional healers (*Idiebo* Urhobo). He or she might elect to stay with his or her master or start practising independently.[56]

The Efficacy of Traditional Medicine

Early European travellers and administrators expressed scepticism about the efficacy of indigenous medicine. Although Talbot believed that the medicine men had great knowledge of the properties of herbs, roots, bark and leaves and that the mingling of these ingredients produced strange results, he contended that "their principal efficacy derived from faith and belief in them."[57] Undoubtedly, faith plays an important role in the potency of any medical system. After the introduction of modern medicine for example, people who developed faith in

55. Interview, Lydia Abamba, Traditional Midwife, Aged 52, Abraka, 6 March, 1993; Eyekpeha.

56. Mume, *Traditional Medicine in Nigeria*, pp. 9-16; Interviews, Enaworu; Edigbe.

57. Talbot, p. 158.

injections felt relieved of their illnesses even when ordinary water was administered on them by injection.[58] Likewise, the attachment of most Delta people to aspects of traditional medicine resulted partly from their faith in their efficacy.

This, however, does not mean that herbs or plant parts do not have medicinal values. It is common nutritional knowledge that vegetables contain vitamins and minerals for body building. Lack of such minerals and vitamins results in deficiency diseases usually cured by sufficient intake of vegetables.[59] Recent studies on Nigerian plants show that many contain properties that effect cure of diseases.[60] The Europeans themselves have also acknowledged the medicinal value of herbs. The popular Quinine which reduced the high rate of European mortality and debility in Africa because of its effectiveness in treating and preventing malaria was derived from the bark of the Cinchona tree.[61] Furthermore, H.E. Ackerknecht has argued that such popular drugs as

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58. Interview, F.O. Esiri, Aged 81, Medical Officer since 1937, in Private Practice since 1951, Warri, 2 February, 1993, (2nd interview) 1 May, 1995.

59. Mume, *Traditional Medicine in Nigeria*, pp.97-98.

60. See J.I. Durodola, "Studies on Certain Medicinal Plants Potential anteneoplastic", Ph.D. Thesis, School of Medicine, University of Ibadan, 1972; G.O. Iketubosun, "Constituents of certain Medicine Plants, Ph.D. Thesis, School of Medicine, University of Ibadan, 1962; R. Schram, *A History of the Nigerian Health Services* (Ibadan: Ibadan University Press, 1971), p.4.

61. L.J. Bruce-Chatt and Joan M. Bruce-Chatt, "Malaria and Yellow Fever the Mortality of British expatriates in Colonial West Africa" in *Health in Tropical Africa During the Colonial Period*. eds. E.E. Sabben-Clare, D.J. Braddey, and K. Kirkwood (Oxford: Clarendon Press, 1980), pp. 45-48.

picotoxin, emetine, strophanthin, serpasil and cocaine were all derived from primitive pharmacopoeias.[62] As far as the Delta peoples, male or female, literate or illiterate, Christian or traditionalist, are concerned the efficacy of herbs is certain, because every family knows the ones to use for home remedies without consulting professional healers.[63]

This argument, however, does not cover other aspects of traditional medical practice: metaphysical causation of diseases, efficacy of sacrifices, the reality of witchcraft and preventive medicine which, to a very large extent, defy practical proof. In addition to faith, we invoke the sense of guilt theory to explain metaphysical causation of diseases especially concerning ancestors and divinities as agents. According to this theory, it is the constant fear arising from a feeling of guilt in an offender that results in a breakdown of some essential organs in him because fear disrupts the normal functioning of the heart, the digestive and nervous systems. The breakdown of these organs some times results in sickness.[64] Harry Sawyerr, a theologian and once the Vice Chancellor of the University of Sierra-Leone, argues in favour of this view. He posits that harmony between the spiritual and the physical entities of man is necessary for a healthy living because disharmony between them makes the spiritual being which is pure to seek to

62. H.E. Ackerknecht, *A Short History of Medicine* (New York: Ronald Press, 1955), p.15.

63. Interviews, Rev. L. Attah, R.C.M. Priest/Lecturer, Aged 60, Abraka, 12 November, 1992; E.O. Ejiko, Baptist Church Elder/University Librarian, Aged 57, Abraka, 16 December, 1992; Itsueli.

64. Mume, *Traditional Medicine in Nigeria*, pp.45-46.

"separate itself from the impure and the individual becomes physically disturbed and fall ill or even die."[65] The relevance of this explanation stems from the awareness, in the offender, of the societal norms and ethics he violated, hence the confession of such violation gives him both spiritual and physical relief. Traditional medical practitioners in the Delta Province emphasise confession in the course of healing some diseases. Modern medicine has recently recognised the concept of stress as it applies to human condition. Causes of stress include such experiences as food deprivation, subjection to extreme temperatures, extreme mental exertion and overwork. Medical science also now recognises that stress causes cardiovascular diseases (hypertension, ischaamic heart disease, peptic ulcer and the neuroses) and can lower the body's defences against infection.[66] Worries and fear arising from a feeling of guilt in a violator of societal norms coincide with mental exertion recognised as one of the causes of stress now believed to cause diseases. These new scientific discoveries therefore strongly support the sense of guilt theory.

The theory offers an explanation for the efficacy of sacrifices. The patient's feeling that he or she has earned forgiveness through a sacrifice, by whatever spiritual forces he offended or purportedly offended, undoubtedly gives him or her both spiritual and physical relief and eventual recovery. The fact that the sacrifices

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65. Harry Sawyerr, "An Enquiry into Some Aspects of Psychic Influence in AfricanUnderstanding of life" in *Themes in African Social and Political Thought*. ed. Onigu Otite (Enugu: Fourth Dimension Publishers, 1978), p. 73.

66. Okpako, p. 231.

are performed by priests or priestesses or representatives of the aggrieved forces convinces him or her that the forgiveness appears real.

This theory, however fails to illuminate our understanding of the following incidents attributed to these metaphysical forces. First, the Delta peoples often attribute the death of some children to the evil deeds of their parents, especially their mothers. M.Y.Nabofa's explanation for this belief is that "it is the mother who suffers the pain of child birth"[67] and therefore would feel his or her death more. Going by the sense of guilt theory, it would have been the person who committed the offence that would have suffered death and not another person. Second, it does not explain the revelation by a diviner that a man died because he recovered and ate his stolen yams. The diviner argued that the owner died because he did not report the recovery of his yams to the divinity which he earlier mandated to seek redress on his behalf. So, the divinity treated him as the thief having found the yams in his possession. Definitely the man could not have developed any feeling of guilt. Third, a child stabbed his father to death and was banished from the community according to custom. But he continued to sneak into the village at night to see his mother. On one of the occasions he sneaked into the village, thunder struck him dead in a room he shared with six other persons who did not sustain any injury. Though he committed a serious crime, the sense of guilt theory does not explain the action of the thunder.[68] We can categorise these incidents

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67. Nabofa, p. 226.

68. Interview and reflections with D.T. Okpako, Lecturer/Pharmacologist, Aged 67, University of Ibadan, 5 March, 1995.

into aspects of the people's medical culture and religion that defy rational explanation but are accepted by faith.

Witchcraft constitutes another controversial aspect of indigenous medical practice because the activities of the practitioners cannot be subjected to investigation and therefore cannot be proved. We shall therefore rely on the views of believers and non-believers for our discussion on the subject. European travellers and the colonial administrators never accepted the reality of witchcraft activities. For example, Allen and Thomson dismissed the claims by some people to be able to transform themselves into any chosen shape as mere pretence.[69] Talbot also doubted the truth in the actions of human beings in the astral world and posited that "the chief cause of this extraordinary belief in and fear of, witchcraft is due to sheer ignorance as to the aetiology of diseases."[70]

Because of the impact of Christianity the reality of witchcraft offered a subject of spirited debate in the National News papers, among the Delta peoples themselves. The proponents upheld the traditional view citing Bible verses on witchcraft activities and the confessions of the practitioners in the Delta to support their claim.[71] On the other hand the opponents denied its existence on the basis that scientific proof was lacking.[72]

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69. Allen and Thomson, p. 382.

70. Talbot, p.226

71. Atimono, "Witchcraft", *Southern Nigeria Defender,* 18 January, 1944, pp.1-4; C.O.O "Witchcraft exists", *Southern Nigeria Defender,* 1 May, 1944, p.3, 1 June, 1944, p.3, 2 June, 1944, pp.3-4.

72. J.N. Enwere, "Witchcraft" *Southern Nigeria Defender,* 23 May, 1944, p.3

Meanwhile the colonial courts handled many cases involving witchcraft accusations. A notable case concerned an Ijo woman, Oghenebrume Pesigha of Diebri village who accused another woman of the same village, Adi Eyemiememe, of witchcraft. The claimant later confessed in the court that she and the defendant were both witches but had quarrelled over the sharing of one of their victims. Pesigha also admitted in the court that she had "devoured ten of her children". The court members, being persons who believed in the reality of witchcraft bound them from continuing their activities.[73]

Confessions by witches and wizards have often been presented as a strong reason to support the belief in the reality of witchcraft among the Delta people. To prove the case for its existence, J.O. Mume, the proprietor of the traditional medicine hospital Agharho in the Ughelli Local Government, Delta State, published "The Confessions of the wizard of Igbinse" who was formerly known as Jeje Karuwa. Jeje confessed that he practised witchcraft for sixty years. According to his account, he became a wizard at the age of six after eating a palmoil soup prepared for him by a relation. On the following night he found himself in an astral body on a journey which landed him at a coven (a meeting place of witches and wizards). He later rose to the highest rank in the guild. He lived in Igbinse, a village in Okitipupa, a Yoruba clan, where he practised. Jeje "confessed" that his activities included killing people, effecting the postponement

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73. "A Witch Devoured Her Ten Children" in *Nigerian Star,* 20 October, 1951, pp. 1 and 4; P.A. Talbot, *Tribes of the Niger Delta: Their Religions and Customs* (London: Frank Cass and Co., 1967), pp. 134 and 140.

of cases in courts, transfer of judges as well as aiding and advising three gangs of thieves. His exploits and notoriety at Okitipupa earned him the name "the wizard of Igbinse". After his confession, he joined J.O. Mume in his hospital as "an associate consultant specialist adviser on wizard infested diseases".[74] Recent studies in Urhobo traditional religion and medicine further revealed the continued belief in the reality of witchcraft by most people because of frequent confessions by the practitioners.[75] The concomitant fear further convinced many Delta people of the necessity of consulting indigenous herbalists for diagnosing and treating diseases believed to emanate from witchcraft activities. They also sought immunity from their attacks. Modern medicine offered no relief from diseases attributed to witchcraft nor did it offer any immunity to the attack of witches and wizards.

Other areas of indigenous medical practice that cannot be subjected to scientific investigation comprise preventive medicines against poisons, charms and dangerous weapons such as machetes and guns. But there is a powerful popular belief in them. Stories abound about people whose skins sharp machetes and bullets could not penetrate because they had rendered themselves immune to such attacks. A well-known instance was Ifiogho Enamoto of Abraka, whose antidote proved very efficacious at several occasions at which he accepted the challenge during the Abraka *Ovwuvwu* annual festivals. A speculation about his death later emerged that he died because the surgeon could not penetrate his skin either by

74. J. O. Mume, *The Confessions of the Wizard of Igbinse* (Agbarho Warri: Oduma Graphic Arts, N.D.), pp. 1-17.

75. Nabofa, p. 229; Ubrurhe, p.72.

knife or injection when he was hospitalised for an urgent operation.[76] Other stories concerned those whose immunity manifested itself during unexpected attacks. Arguing the case for traditional immunisation in a newspaper article, Otimomo cited an example from another newspaper article on how:

> A certain trader was cut all over his body by some highway men, and all that was seen on his body were bruises. This hero managed to get home with his bicycle and baggage.[77]

Many Delta people acknowledged the efficacy of these aspects of indigenous medicine. The belief continued to affect their health care psychology after the introduction of modern medicine and led to the continued patronage the indigenous herbalists, the only providers of such medicines, enjoyed.

The seekers of these protective medicines were, however, aware that the indigenous immunisation system often failed and the possessors fell victim to attacks. For example, in 1991 two people received serious injuries from machete cuts during the Abraka *Ovwuvwu* festival when they accepted the challenge.[78] But they usually attributed the failure either to the inability of the immunised to keep to the instructions of the herbalist or that the person challenging him used a more powerful medicine to neutralise his immunity.[79] The remedy would not be to stop seeking such protections but to search for herbalists of repute. All these mysterious aspects of indigenous medical practice must remain relegated to the

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77. Atimono, "African Super Science" in *Southern Nigeria Defender,* 18 January, 1944, p. 1-4

78. Interview, Okotie.

79. *Ibid.*

realm of superstition by all scientific minded people as long as they cannot be subjected to empirical studies.

We have tried to show the Delta peoples' faith in the efficacy of their indigenous diagnostic, preventive and curative methods of disease management which evolved within their environment. The herbalists diagnosed and treated diseases of natural causation with herbs and other therapeutic methods. While the diviners diagnosed diseases of metaphysical causation, the priests propitiated the purported aggrieved forces through sacrifices. The treatment of diseases believed to be caused by such spiritual forces as ancestors, divinities, evil spirits and witches or wizards exemplifies what Steven Feierman has described as cultural interpretation of disease and healing in Africa. He posited that each society has its own body of cultural knowledge for the interpretation of illness. Hence the patient's condition is interpreted in the light of this knowledge to name the condition and arrive at a course of theraphy.[80] This factor helps to explain the efficacy ascribed to divination, propitiation and incantation. The Delta peoples' medical culture as described here prevailed in the pre-colonial period. Hence the diviners, herbalists and priests remained important personages in the society because of their roles in the restoration of health to the sick among other functions. Only new religious ideas started perforating these cultural beliefs. An internal religious movement, the *Igbe,* proved most successful before colonial rule.

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80. Steven Feierman, "Struggles For Control: The Social Roots of Health and Healing in Modern Africa" in *African Studies Review* vol.28, 2/3, 1985, pp. 74-76.

Development Affecting Customary Ideas

Several decades before the advent of modern medical institutions an internal religious movement, *Igbe*, had already begun to alter indigenous ideas concerning health and treatment of the sick. It challenged some basic religious and therapeutic beliefs of the people. Its members denied the existence of divinities and refused to venerate their ancestors. They professed absolute faith in the Almighty God. Not only did the *Igbe* movement challenge local religious beliefs, it also introduced a new healing method which comprised confession, intercession, petition, dancing and licking the *orha* (white chalk), the symbol of the religion which also constituted the only *materia medica.* The members denounced the use of herbs in healing and professed to cure diverse diseases as well as to detect and protect people from the havoc of witches and wizards through their own methods.[81]

The religion originated at Kokori, an Urhobo town and the home town of its founder, Ubiesha Etakpo. Scholars of the *Igbe* religion dated its foundation to the eighteenth century. Ubiesha also initiated its expansion by inviting elders from other clans and other ethnic groups: Aboh, Ukwuani, Itsekiri and Isoko, to whom he revealed his call. He succeeded in converting these elders and through them the religion spread to other parts of the Warri Province.[82] After Ubiesha's death in

81. M.Y. Nabofa, "Igbe Religious Movement" in *Urhobo People* ed. Onigu Otite (Ibadan: Heinemann Educational Books, 1982), p. 236.

82. *Ibid.*, p.233.

1920,[83] the original *Igbe* split into four independent denominations with headquarters at Orogun, Benin, Oweh and Ozoro.[84] Moreover, other *Igbe* sects: *Igbe* Everhe, *Igbe* Ame and *Igbe* Oghene Uku, claiming independent origin came into being. These new sects and denominations helped to expand the religion to other parts of the country.[85] The popularity of the *Igbe* healing methods and the claims by the members of their ability to cure such maladies as leprosy, impotence, deafness, dumbness, lunacy and infertility also enhanced its expansion. It reached Benin around 1870. The Oba of Benin Overenmi, visited Ubiesha few years before his deportation in 1897. It later spread to many parts of Southern Nigeria including Benin, Onitsha and Ondo Provinces.[86]

By introducing a new healing method and denouncing the use of herbs without discouraging the use of modern medicine introduced by the Europeans, the original *Igbe* (Ubiesha) had positive implications for the development of modern medicine.[87] The rate at which the Delta peoples embraced the *Igbe*

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83. If Ubiesha died in 1920, then the founding date of the religion appears doubtful. There is no note explaining that he lived up to or more than 200 years. It is unlikely he did.

84. Nabofa, "Igbe Religious Movement," p. 240.

85. *Ibid.*, pp.232-240; Erivwo, pp. 152-158.

86. Imonieroh G. Ohworode, "The History of Igbe and Its Entire Organisation: A Case Study of Igbe Ubiesha Traditional Religion", B.A. Project, Department of Arts, History Unit, Bendel State University, Abraka, 1987, p.9.

87. Other Sects use herbs but all encourage the use of modern medicine.

movement demonstrates their inclination to change. The *Igbe* movement prepared the way for more virile and organised agents of change: the Christian missions, commercial companies and the colonial administration, which introduced a new medical culture. In their characteristic manner, the Delta peoples welcomed, encouraged and contributed to the development of modern medicine. They, however, welcomed modern medicine as a complement and not as a substitute for indigenous medical services because they did not accept the entire corpus of modern medicine indiscriminately. They considered such factors as its effectiveness in solving their health problems, the extent to which its procedures conformed with or contradicted their social values, availability of modern medical services, cost of drugs and its capability to cover all their health needs in accordance with their interpretation or understanding of what constituted good health and the functions of medicine. Where modern medical practices failed to satisfy their health needs, they continued with the indigenous system, no matter the opinion of the church or the state. The observation of the District Officer of Aboh Division, Ian Robert Penicuick Heslop, in 1941 is very apt:

> Belief in witchcraft is implicit and universal even among the well educated, and the Native Dibia (which sometimes effect quite remarkable cure) is preferred to the Medical Officer, Sapele by the bulk even of the Government and Native Administration staffs.[88]

What actually emerged from the process of the development of modern medicine amounted to medical pluralism. As we discuss the development of modern

88. NAI, Kwale Dist. 1/141 vol. IX: Annual Report, Aboh Division, 1941, p.83.

medical services in subsequent chapters, we shall be highlighting why aspects of modern medicine received total or partial acceptance, the changing attitude of the Delta people over time and why they continued to consult traditional medicine men and women.

CHAPTER TWO

INSTITUTION OF GOVERNMENT MEDICAL POLICY IN TOWNSHIPS 1906-1929

Prelude to Government Medical Services

Before the formal introduction of colonial medical services, European explorers, traders and Christian missionaries operating in Warri Province had used western medicine to treat their agents. They did not, however, establish medical institutions like their counterparts in other parts of Nigeria and Africa. For example, in Calabar, Abeokuta (Nigeria) and Mengo (Uganda) the missionaries opened the first dispensaries, while the Dutch Indian Company opened the first hospital in South Africa.[1] Besides treating European agents, they encouraged African agents and sometimes their hosts to utilise these services. Portuguese traders who interacted with the Delta people as early as 1515 introduced western medicine to the areas in which they operated along the Escravos, Forcados, Benin and Ramos rivers.[2] Between the sixteenth and the nineteenth centuries Portuguese Roman Catholic Missionaries in the Itsekiri kingdom also provided European

1. A.. Adeloye, *African Pioneers of Modern Medicine: Nigerian Doctors of the Nineteenth Century* (Ibadan: Ibadan University Press, 1985), pp.44-45; W.D. Foster, *The Early History of Scientific Medicine in Uganda* (Dar es Salam: East African Literature Bureau, 1974), pp.2-13; E. Burrows, *A History of Medicine in South Africa Up to the End of the 19th Century* (Cape Town: N.P., 1958), p.180.

2. A.F.C. Ryder, "An Early Portuguese Trading Voyage to the Forcados River" *Journal of the Historical Society of Nigeria (JHSN)*, 1(4), 1959, pp.294-296.

methods of treatment.[3] A hospital founded by their home government at Sao Tome in 1504, treated their nationals in West Africa as well as African agents. Indigenous Itsekiri missionaries such as Dom Domingos, the son of the Olu of Itsekiri, who read theology in Portugal between 1600 and 1610 also had access to Portuguese medical services.[4] Ralph Schram has, however, rightly posited that the European medicine and treatment of those days fell short of scientific or modern medicine.[5] They were yet evolving.

Medical doctors accompanying the various explorers of the Niger who reached the Delta region: the Lander brothers (1830), Macgregor Laird (1832), the Niger Expeditions of 1841, 1854 and 1857, extended European health services to their hosts. For instance, during the 1841 expedition Dr. M.C. Williams vaccinated four villagers at Akassa and many others in a neighbouring village.[6] The successful experiment by Dr. William Baikie during the Niger expedition of 1854, when he used quinine for both cure and prevention of malaria, marked a break through in medical science in Africa. The crews of previous expeditions suffered very high mortality and debility rates because they used quinine only as a curative measure.[7] Following the reports of Doctors Boyle and Alexander Bryson in 1826 and 1847

1. A.F.C. Ryder, "Missionary Activities in the Kingdom of Warri to the Early 19th Century" *JHSN*, II(1), 1960, pp.2-23.

2. A.F.C. Ryder, "Dom Domingos: Prince of Warri" *ODU*, 4 1956, pp.33-40.

3. R. Schram, *A History of the Nigerian Health Services*, pp.3-4.

4. W. Allen and T.R.H. Thomson, *Trotters Expedition to the Niger* Vol. I. (London: Frankcass, 1968), p.170.

5. *Ibid.*, p.272.

respectively, Baikie issued daily draughts of six to eight grains of quinine to the crews and consequently none died during the expedition.[8] From then, regular administration of adequate dosages of quinine became a foundation stone of modern medical policy in Africa. Respective European companies and missionaries as well as British agents operating within the Niger Delta region and other areas in Nigeria where medical institutions did not exist treated themselves through regular intake of quinine.[9]

Besides introducing modern medicine, Christian missionary activities and teachings promoted the use of modern medicine in the Delta area. The missionaries mounted powerful propaganda against the indigenous religion and medical culture. They condemned indigenous beliefs concerning ancestors, divinities, spirits and therapeutic processes and methods such as divination, sacrifices, incantations, festivals as well as immunisation against witchcraft, poisons, supernatural forces and some human physical attacks. The Church prohibited Christian converts from consulting traditional medical practitioners and required indigenous medical practitioner converts to denounce their practices

8. L.J. Bruce-Chatt and Joan, "Malaria and Yellow Fever: The Mortality of British Expatriates in Colonial West Africa" in *Health in Tropical Africa During the Colonial Period* ed. E. Sabben Clare, D.T. Bradley and K. Kirkwood (Oxford: Clarendon Press, 1980), pp.45-46.

9. Daniel R. Headrick, *The Tools of Empire: Technology and European Imperialism in the 19th Century* (Oxford: Oxford University Press, 1981), pp.69-73; James S. Coleman, *Nigeria: Background to Nationalism* (Benin City: Broburg and Winstrom, 1986), pp.41-44.

publicly and destroy all visible symbols of traditional healing.[10] Though the Church obtained only partial success in its propaganda against traditional practices it developed a campaign against indigenous medicine. Later the missions pinpointed the provision of health care service as a crucial area of evangelical emphasis.

Incidentally, missionary presence preceded the establishment of modern medical institutions everywhere in the province and thereby prepared the ground for the acceptance of modern medicine. For example, before the opening of government hospitals in Warri and Sapele, Bishop James Johnson of the Niger Delta Pastorate had founded Anglican Churches there in 1901. Subsequent visits by Johnson between 1904 and 1907 led to the opening of new stations and strengthening the earlier ones.[11] Other Christian denominations followed suit. In 1912, Rev. Father Louis Cavagnera visited Warri and in the following year founded the Warri Catholic Church.[12] In 1913 and 1914 Rev. J.D. Aitken of the Niger Mission toured Isoko land where indigenous traders had earlier propagated the Anglican faith. His efforts resulted in creating an Isoko District of the Anglican Church in 1914.[13] From these early centres on the coast Christianity

10. Interviews, B.J. Itsueli,, Aged 56, Catholic Church Elder/Lecturer, Abraka, 24 February, 1993; John Denedo, Aged 52, R.C.M. Church Leader/Librarian, Abraka, 9 February, 1993; D.O.U. Adube, Aged 53, C.M.S. Priest/Lecturer, Abraka, 22 January, 1993; E.O. Ejiko, Aged 58, Baptist Church Elder/Librarian, Abraka, 16 December, 1992.

11. S.U. Erivwo, *Traditional Religion and Christianity in Nigeria*, p.86.

12. Ibid., p.109.

13. O. Ikime, *Niger Delta Rivalry*, p.162.

spread rapidly to the hinterland. By 1930, Christian denominations of various kinds were established in most towns and village groups in the province.[14]

The missionaries also conceived Western education as an essential tool of evangelism and spreading Western ideas to children in their most impressionable stage of development.[15] They therefore embarked on indiscriminate opening of schools. During Bishop Johnson's visit in 1901, he opened schools at Warri and Sapele.[16] In fact, during this period the opening of a Church coincided with the beginning of Western education. Catechists organised Sunday schools and Bible classes to prepare their converts for baptism and confirmation examinations. Reading and writing were considered essential tools in understanding the Bible. In addition, the missionaries opened more formal schools. Before 1926, when the colonial government introduced an Education Code regulating the opening of mission and private schools, schools did not require specifications or approval and could be conducted in the compounds of Church leaders or teachers.[17] By the end of 1927 the Christian missions had established forty-five regular schools in the province.[18] The colonial government also opened schools in the province.

14. Erivwo, p.25; E. Okolugbo, *A History of Christianity in Nigeria: The Ndosumili and the Ukwuani* (Ibadan: Day Star Press, 1984), p.32.

15. E.A. Ayandele, *The Missionary Impact on Modern Nigeria 1882-1914: A Political and Social Analysis* (London: Longman, 1966), p.285.

16. Erivwo, p.86.

17. A.B. Fafunwa, *History of Education in Nigeria* (London: George Allen & Unwin, 1974), pp.125-126.

18. NAI, CSO 26/2/11857 Vol. V: Annual Report, Warri Province, 1927, pp.163-164.

Before 1906, it had opened boys' schools at Warri (1903), Sapele (1904), Aboh (1905); girls schools at Warri and Sapele (1904), and a technical school at Warri in 1903. By the end of 1906 all government schools enrolled 259 pupils.[19] These government and mission schools and their associated churches served as agencies for expounding Western ideas of all kinds, including health and healing. Instructions relating to health education carried out in these early schools fostered the acceptance of Western medicine. Hygiene and health education, being subjects on the school curriculum, featured on school time-tables. Pupils received formal lessons on sanitation, personal cleanliness, prevention of diseases and first-aid treatment for various ailments and accidents in accordance with modern methods. The schools maintained first-aid boxes for treating minor ailments and for demonstration lessons. In addition, inspection of school children during which time they received instructions on personal hygiene constituted a regular daily practice during morning assemblies.[20] These pupils who became the first generation of Western educated citizens continued to spread these new ideas in the province. They were among the first citizens to welcome modern medical services when they became established in the province.[21]

19. Annual Report, Southern Nigeria, 1906 (Lagos: Government Printer, 1908), pp.209-210.

20. Annual Report, Nigeria, 1921 (Lagos: Government Printer, 1922), p.69.

21. Interviews, Francis Anho, Aged 80, Retired teacher, Abraka, 21 August, 1991; Esiri.

Before the colonial administration institutionalised modern medical services, it provided rudimentary services to its European and African workers like the non-governmental agencies. In 1901, dispensers started to issue quinine to prisoners and colonial employees directly connected with the administration in the Warri Province. The extension of this practice to non-government workers within this period was to a large extent motivated by self interest, meant to:

> create around the European settlements non-malarial zones which could be gradually increased in size until they meet other such zones and so in course of time large tracts of country would become, to a large extent free from malaria.[22]

The advent of a colonial government, the spread of Christianity, the opening of schools and the presence of commercial companies created new social groups comprising Christians and Western educated citizens in the employ of government and commercial companies. They initiated the acceptance of Western medicine throughout the province. These new social groups concentrated in the coastal towns of Sapele, Warri, Burutu, Koko, Aboh and Forcados which the colonial administration designated townships, thereby polarising the province into township and rural dwellers. The town dwellers pioneered Western medical ideas and spread them to the rural areas by popularizing the effectiveness and other advantages of modern medical care.

Between 1906 and 1929, the colonial state pioneered and dominated the

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22. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.170; Annual Report, Western Division, Southern Nigeria 1905 in Nigerian Government Gazette May-December 1906, Vol. 1, p.6.

establishment of medical institutions in the province. Before then (1905), it appointed the following medical officers, Doctors Martin Eric O'Dea, James Falion Stewart and John Brabant Bate to Warri, Sapele, and Forcados respectively as District Medical Officers.[23] These appointments inaugurated a system of medical services in the Warri Province in line with the other British possessions. As the district was the smallest unit of colonial administration and development, the District Medical Officer supervised the implementation of all medical and health policies in his district. R. L. Cheverton, a former Director of Medical Services Nigeria observed that:

> On the clinical side the bush doctor had to be a jack of all trades, as besides knowing his medicine and surgery, he had to have a working knowledge of forensic medicine in order to assist the police and to attend court as a professional witness.[24]

District Medical Officers undertook routine inspection of school children to determine the state of health of the community. Besides, they had administrative tasks such as preparing and submitting to the central stores requisition for drugs and instrument for their hospitals and rural dispensaries or health centres and the preparation of annual reports.[25] District medical annual reports and other medical reports constitute an invaluable and indispensable source for this study and any study on colonial medical history.

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23. Annual Report, Western Division, Southern Nigeria, 1905, p.16 and 21.

24. R.L. Cheverton, "The District Medical Officer" in *Health in Tropical Africa During the Colonial Period*, p.140.

25. Ibid.

Government Medical and Health Institutions 1906-1929

A. Hospitals/Dispensaries

The first step in the evolution of modern medical policy consisted of establishing an institutional frame work. From 1900, the colonial state extended the policy that regulated the opening of modern health care services in the Lagos Colony to the protectorates. Three earlier ordinances enacted for use in Lagos in the nineteenth century were extended to the Warri Province. They determined the location of modern medical institutions in the province. First, the Prisons Ordinance number nine of 1876 stipulated that sick prisoners should be removed to a hospital for treatment while a dispenser should reside in the prison, attend to the prisoners and submit a report on those in the infirmary to the Medical Officer.[26] Second, the Pilotage and Harbour Ordinance number three of 1878 mandated Health Officers to visit every ship in harbour at least twice a week and remove any sick persons on board to a hospital for treatment.[27] Third, the Towns and Police and Public Health Ordinance number ten of 1878 provided that sick persons in the townships should be treated in a hospital. It also required that public health measures should be instituted in the townships.[28]

These ordinances led to the opening of hospitals at Warri, Sapele and Forcados, the largest (second class) townships and seaports in Warri Province at

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26. *Laws of Colony of Lagos Vol. I* (London: Stevens and Sons, 1902), pp.192-213.

27. Ibid, pp.354-369.

28. Ibid, pp.383-389.

the time. Sapele and Warri also possessed the largest prison yards.[29] The other District headquarters: Aboh, Brass and Kwale designated third class townships also had prison yards. By 1904 construction work at the Quarantine Station Forcados had begun while the building of the European Hospital at Sapele and the African Hospital at Warri started in 1905, the year the Medical Officers assumed their posts at Warri, Sapele and Forcados.[30] The African Hospitals at Warri, Sapele and Forcados; the European Hospital (Sapele) and the Quarantine Station at Forcados officially opened in 1906.[31] Three years later the government opened a European Hospital at Warri and rebuilt the African Hospital at Sapele. In 1909, a second Medical Officer, Dr. M.E. O'Dea, assumed duty at Warri because the work load had become too heavy for one Medical Officer.[32]

These early hospitals were constructed according to a very simple design. The European Hospital (Warri) and the Quarantine Station (Forcados) were built of concrete blocks while others were built of bricks.[33] Their capacity varied

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29. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.61; J.O.S. Ayomike, *The Ijaw in Warri* (Benin City, Mayomi Publishers, 1990), p.4; Annual Report, Western Division, Southern Nigeria, 1905, p.6.

30. Colony and Protectorate of Southern Nigeria, Blue Book 1906, pp.J12-15.

31. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, pp.339-348.

32. NAI, CSO. 1/15 Vol.12: Despatch to Secretary of State, 1909, p.121.

33. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.339; Annual Medical and Sanitary Report, 1919-1921, in Annual Report, Nigeria, 1921, p.27ff.

between two and seven wards. Table two shows the construction costs of hospitals built in 1906. Tables three and four show hospital wards and beds in 1915 and 1922 respectively.

Table II
Estimated and Actual Costs of Building Hospitals 1906

	Hospital	Estimated Cost £	S	D	Actual Cost £	S	D
1	Forcados African Hospital	329	9	2	329	3	6
2	Forcados Quarantine Station	1420	0	0	1483	12	6
3	Sapele African Hospital	170	0	0	170	0	0
4	Sapele European Hospital	700	0	0	512	3	7
5	Warri African Hospital	300	0	0	279	11	2
6	Warri European Hospital	2500	0	0		na	

Note: n.a. means not available

Source: Blue Book, Southern Nigeria, 1906, pp. J13-15; Government Gazette Southern Nigeria, May - December, 1906 vol.1, p.865.

Table III
Number of Hospital Wards, Warri Province 1915

	Hospital	Total No. of Wards	Male	Female
1.	Forcados African Hospital	2	1	1
2.	Forcados Quarantine Station	2	n.a.	n.a.
3.	Sapele African Hospital	4	3	1
4.	Sapele European Hospital	2	n.a.	n.a.
5.	Warri African Hospital	7	n.a.	n.a.
6.	Warri European Hospital	6	n.a.	n.a.

Note: n.a. means not available

Source: Blue Book, Nigeria 1915, pp. DD 13-14

Table IV
Number of Hospital Beds, Warri Province, 1922

	Hospital	Total No. of Beds	Male	Female
1.	Forcados African Hospital	16	12	4
2.	Forcados Quarantine Station	4	4	-
3.	Sapele African Hospital	18	16	2
4.	Sapele European Hospital	4	4	-
5.	Warri African Hospital	30	24	6
6.	Warri European Hospital	4	6	-
7.	Warri Infectious Disease Hospital	20	20	-
8.	Sapele Infectious Disease Hospital	8	8	-

Source: NAI, CSO 26/2, 09908 vol.1,
Medical and Sanitary Department, Annual Report, Nigeria, 1922 p.21

These tables reveal the limited nature of institutional services as well as facilities in the existing hospitals. Except for the Infectious Disease Hospitals built as an emergency measure to check the spread of the 1918 influenza pandemic, there was no further institutional development before 1930, after the construction of the Warri European Hospital in 1909.

The 1918 influenza pandemic necessitated the opening of Infectious Disease Hospitals because of the rate at which it was spreading throughout the world and its high mortality rates. The flu broke out simultaneously in Sierra Leone, New England and Brest (France) in August 1918 and in a matter of months it spread to all parts of the world. It reached Britain in November. The mortality rates were high and unprecedented comparable only to the Black Death that swept over Europe and Asia in the fourteenth century. In Nigeria the epidemic broke out in September 1918, believed to have been transmitted by sailors from Ghana. It spread to all parts of the country with about eighty percent of the population falling victim. Nigeria recorded a conservative mortality rate of about three percent (260,000 in the Southern Provinces, 200,000 in the Northern Provinces and 1.5 percent of the population of Lagos). Panic developed among town dwellers, prompting them to flee to their natal villages. This further aided the spread of the disease as "healthy" carriers went into the interior. The flu paralysed social and economic activities, resulting in a serious famine that caused a high death toll of "able bodied young men and women." D.C. Ohadike strongly posits that the concomitant famine compelled the peoples of the Lower Niger to embrace cassava

cultivation which they earlier derided as a form of food security.[34]

The Colonial Office postponed action to check the pandemic until it reached Britain. Only after most colonies had already suffered high death tolls did it attempt to set up a programme to deal with the ravage of the disease. Within West Africa colonial administrators took initiative to control the flu. Their measures included house to house visitation to detect the sufferers, distribution of drugs, inspection of ships and opening maritime quarantines to check the influx of carriers from abroad. In Nigeria the colonial state opened Infectious Disease Hospitals at Lagos, Warri, Calabar, Sapele and Abeokuta. Except for Abeokuta, all the hospitals were situated at seaport towns to confine infected sailors from abroad.[35] This spirit of institutional build-up tapered off as the epidemics subsided and no new institutions were proposed until 1930. In fact the European Hospital Sapele was closed down in 1925 due to under-utilisation of facilities. That year it admitted only two patients and thereafter disappeared from the list of hospitals in the province.[36] Only the European Hospital Warri remained to cater for European patients.

Outside Warri, Forcados and Sapele dispensaries served the medical needs

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34. D.C. Ohadike, "The Influenza Pandemic of 1918-19 and the spread of Cassava Cultivation on the Lower Niger: A Case Study of Historical Linkage". *Journal of African History* 22(3), 1981, pp.383-390.

35. Sandra M. Tomkins, "Colonial Administration in British Africa during the Influenza Epidemic of 1918-19", *Canadian Journal of African Studies*, 28(i), 1994, pp.64-70; Schram, pp.189-191; Annual Medical and Sanitary Report, 1919-1921 in Annual Report, Nigeria 1921, pp.27-49.

36. Nigeria, *Blue Book*, 1925, Section 26, p.519.

of the people. Though the colonial policy emphasized stationing medical officers at the district headquarters, [37] some districts had no resident medical officers most of the time within this period. For example, between 1906 and 1929, the Kwale district had no resident medical officer at all, but was served by monthly visits by the medical officers of Sapele district. In the rest of the time, a dispenser and a hospital servant resided at Kwale station and provided rudimentary treatment for prisoners, policemen and administrative staff as well as to administer vaccinations in the neighbouring villages.[38] Medical officers served in Aboh district only between 1906 and 1914.[39] No hospital or even dispensary was established at Aboh within this period. The fall in number of vaccinations in the district from 1,220 in 1906 to 563 in 1909 and 475 in 1910 suggests that medical and health work in the district lapsed significantly.[40] A medical officer served in the Brass district for only one year. Doctor Augustus James Arthur Browne who instituted

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37. Annual Report, Western Division, Southern Nigeria, 1905, pp.16 and 21.

38. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.297; Annual Report, Western Division, Southern Nigeria, 1905, p.21.

39. Annual Report, Colony and Protectorate of Southern Nigeria 1906, p.297; Annual Report, Southern Nigeria, 1910, pp.475 and 551.

40. Annual Report, Colony and Protectorate of Southern Nigeria 1906, p.298; Annual Report, Medical Department, Southern Nigeria, 1909, p.12; Annual Report Southern Nigeria, 1910, p.551. Note: Aboh was a sub-district under Onitsha District in the Onitsha Province between 1914 and 1929 see NAI, CSO 26/2/11857, Vol. VII: Annual Report: Warri Province, 1929, p.2.

medical and health services there in 1906,[41] was transferred at the end of that year and not replaced. In 1926, the District Officer, Mr. Harry Maddocks, complained that:

> It is deplorable that a Division where there are at least twelve Europeans, a large staff who are entitled to free treatment and from 30-50 prisoners that some arrangement cannot be made for medical attendance. If a medical Officer cannot be spared at least a dispenser might well be left behind.[42]

After the transfer of Dr. Browne, the medical officers of Akassa district in the Eastern Provinces assumed control of Brass district as well, through monthly visits. Throughout this period no separate statistics exist for Brass district. Data for that area were combined with those of Akassa in Owerri Province [43].

Besides these district headquarters, the government provided dispensary services at Burutu, a coastal third-class township. When the Marine Department closed its transport office at Burutu in 1926, the provincial authorities took possession of the room and transformed it into a doctor's consulting room. It opened a dispensary with a resident dispenser while the medical officer at Forcados paid monthly visits to the dispensary to oversee the dispenser's activities as well as to treat serious cases.[44]

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41. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.297.

42. NAI, CSO 26/2/11857, Vol. IV: Annual Report, Warri Province, 1926, p.62.

43. Southern Nigeria, *Blue Book*, 1907, p.327.

44. Annual Report, Warri Province, 1926, p.65.

The only attempt to extend medical services to people outside the townships and district headquarters concerned the practice of selling quinine in the villages around Sapele township, a policy begun by Dr. George Fitzjames Darker in 1906. He publicized this through announcements in the Sapele market, Native court and dispensary, stressing the efficacy of quinine in curing and preventing malaria in adults and children.[45] So far, no evidence exists to show that the Local authorities introduced this measure in other townships. Moreover, it was discontinued in Sapele after 1906.

B. **Preventive Measures and Medicine**

The second step towards entrenching health policy focussed on the implementation of laws on preventive measures along the lines of recent developments in Europe. The British Public Health Act of 1875 widened the scope of preventive measures and medicine to include sanitation, hygiene and other aspects of community health such as drainage and sewage disposal, the creation of potable water supplies, the isolation of sufferers of infectious diseases, better housing, inspection of food supplies and school children as well as the control of contagious diseases.[46] The colonial government incorporated similar measures in the Towns, Police and Public Health Ordinance Number Ten of 1878 and other laws.[47] The efforts of the Nigerian colonial administration to implement such

45. Nigeria, Government Gazette, 20 June, 1906, p.206.

46. E.H. Ackerknecht, *A Short History of Medicine*, pp.195-202.

47. *Laws of the Colony of Lagos Vol. I*, pp.383-398.

measures in Warri Province became one of the most important developments in establishing modern medical tradition.

Sanitation

Sanitation policy during this early phase of colonial rule focused on three areas: (1) anti-malaria measures, (2) disposal of human waste, and (3) improving the water supply. The colonial administration considered that none of the towns and district headquarters met the metropolitan standard of good sanitation. Swampy coasts encouraged mosquito breeding in the Warri, Sapele, Forcados, Aboh, Brass and Koko towns. Evergreen grasses and mangrove trees thrived uncontrolled in the creeks and swamps around these towns. Rusty tins and broken calabashes littered compounds while indiscriminate defecation and urination characterised people's personal daily habits.[48]

The provincial authorities initiated measures to improve the sanitary conditions of Warri, the provincial headquarters, and other towns in 1906. The first action was to destroy the old Warri town and construct a new one, justifying the measure on the grounds that the old structures in the town and the environment were unsanitary. The District Officer, Arthur Lionel Critchin Laborde observed that the old town represented a health hazard to the European reservation and praised the plan of the new town which had been:

> Laid out in streets with a public square, the houses being built in correct alignment and due regard being paid to the question of the town latrines.

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48. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.171.

He enthused that in a few years Warri would be "one of the cleanest, best built and sanitary towns in West Africa".[49]

Second, the government instituted malaria control measures in the mosquito infested coastal towns. Local administrators deployed measures already proved effective in other tropical towns in the British Empire such as Lagos, Kampala and Freetown. Sir William MacGregor, Governor of Lagos between 1899 and 1904, had earlier introduced malaria control measures. These consisted of "House screening, drainage of swamps and administration of quinine to African children". In Kampala anti-malaria policy comprised "inspection of premises, filling in breeding places, drainage, quinine distribution and racial segregation".[50] Similar measures were deployed in Warri and other coastal towns in the province. In addition, the provincial authorities authorised the clearing of bushes around dwelling places, reclamation of swamps; the removal of old tins, broken bottles and all kinds of water containers from compounds as well as pouring kerosine and oil in stagnant pools of water. Sanitary labourers pruned shade trees and herbage, and covered wells and tanks. The government provided mosquito proof windows in government quarters and encouraged the use of mosquito nets.[51] By the end of 1906, these measures had been successfully instituted in Warri and to a lesser

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49. Ibid., p.298; Annual Report, Medical Department, Southern Nigeria, 1909, p.12; Annual Report, Southern Nigeria, 1910, p.551.

50. B.E.C. Hopwood, "Primary Health Care in Uganda 1894-1962" in *Health in Tropical Africa During the Colonial Period.* pp.47-49; Schram, pp.118-119.

51. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.171.

extent at Aboh, Sapele, Forcados, Burutu and Koko.[52] To enforce public health policy, the provincial authorities appointed sanitary inspectors and overseers to enforce sanitary measures in the towns. Their duties embraced refuse disposal, routine inspection of compounds and markets. More importantly, they educated the people on all sanitary measures.[53] By 1909, the Warri Sanitary Inspector deployed a team of labourers to assist him.[54] After a fairly long period this team increased by the addition of two European Inspectors in 1921, and in 1928, a specialist medical officer of health who lived in Warri.[55]

Another major area of concern consisted of disposal of human excreta and refuse. In 1909, the Health Department introduced a sewage system for disposing human excrement at Warri and other coastal towns in the Central Province where sewers served government and European quarters, while a sanitary canoe dumped all refuse and latrine waste from other parts of the town into the stream.[56] Two water latrines also served some parts of the town. At Sapele dry earth closets and river latrines were employed in the European reservations. Two river latrines served the rest of the town. Forcados also adopted the sanitary canoe system.[57]

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52. *Ibid.*, p.131.

53. *Ibid*, p.171.

54. Annual Report, Medical Department, Southern Nigeria, 1909, p.5.

55. Annual Report, Nigeria, 1921, p.68; NAI, CSO 26/2/11857 Vol. VI: annual Report, Warri Province, 1928, p.65.

56. Annual Report, Medical Department, Southern Nigeria, 1909, p.5.

57. Annual Report, Southern Provinces, 1909, p.49.

In the interior stations the trenching system of burying excrement in forests or uncleared land far from human settlement prevailed.[58] Dumping refuse into bodies of water or unto land just outside city (or town) limit was the most used method of disposing such wastes in the colonial as well as in the Western cities during this period.[59] At the end of 1909, the District Officer, William Birell Gray, approved the installation of incinerators at Warri for burning other solid wastes. A system adopted later at Warri and other towns.[60]

Administrative efforts to stop random defecation and urination in these towns proved a losing battle partly because of lack of revenue to build the required facilities. The local administrators provided only two public latrines each at Warri, Sapele and Forcados in 1925. These failed to serve the needs of the fast growing towns. Moreover misuse and lack of proper care made them very uncomfortable for the users who detested the unpleasant odours and therefore preferred to continue their former habits.[61]

Although provision of pure water was a declared goal of the local government, it did not achieve anything significant in this direction. The main

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58. Annual Report, Medical Department, Southern Nigeria, 1909, p.37.

59. Spencer H. Brown, "Public Health in Lagos, 1850-1900: Perceptions, Patterns, and Perspectives". *The International Journal of African Historical Studies* 25 (2), 1992, pp.358-359.

60. NAI, CSO 26/2/11857, Vol. III: Annual Report, Warri Province, 1925, p.22.

61. Ibid., p.21.

sources of water consisted of natural rainfall, the rivers, streams and wells. European administrators introduced tanks in European quarters for storing water and instituted precautions to ensure a personal pure water system at the domestic level. They insisted on boiling water and using filters. Members of their domestic staff learned to apply these new techniques which the teachers also taught in the schools.

Public awareness of the importance of sanitation policy slowly grew through health education on an individual or group basis. While African domestic servants of the Europeans learnt from their masters through practical experience and informal instructions during the course of their domestic duties, the sanitary inspectors and overseers gave instructions and advice on personal hygiene, drinking pure water and keeping surroundings clean in the course of carrying out their official duties.62 As we have shown earlier, similar instructions and demonstration lessons featured in the schools during morning assemblies and Hygiene and Health Education lessons.[63] The pupils and all others who acquired the knowledge of modern health habits were encouraged to practise their new knowledge in their homes and disseminate such habits and instructions to their people.

Preventive Medicine

In addition to opening Infectious Disease Hospitals to control the spread of

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62. F.A.. Jenne and W.H. Greene, *Turner's School Health and Health Education* (St. Louis U.S.A. C.V. Mosby Company, 7th ed. 1976), p.8; Annual Report, Nigeria, 1921, p.69.
63. Annual Report, Nigeria, 1921, p.69.

infectious diseases and the distribution of quinine for the cure and prevention of malaria, the government instituted laws for the control of smallpox and other diseases in the townships and communities. The Towns and Police and Public Health Ordinance Number Ten of 1878 authorised the treatment and control of smallpox cholera, yellow fever and other epidemic diseases.[64] Smallpox, an endemic disease in this area, received early attention through the enforcement of the Vaccination Ordinance Number Eleven of 1893. Traditional treatment for smallpox called for the isolation of the patients because of the stigma associated with it. Thus they tended to escape notice because they remained in hiding.[65] In order to locate the sufferers the Vaccination Ordinance empowered public vaccinators to enter any house to search for people suspected to have smallpox, vaccinate them or prosecute them if they resisted vaccination. They also vaccinated all people within any community where an outbreak of smallpox occurred in order to control the spread of the epidemic.[66] Immunisation against smallpox started in the towns and government stations in 1906 and continued throughout the period covered by this chapter. Table V illustrates the expansion of vaccination measures in the various districts in the province and attests to the efforts of the colonial administration to eradicate smallpox.

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64. *Laws of the Colony of Lagos Vol. I.*, pp.383-398.

65. Interview, Francis Anho, Aged 80, Retired School teacher, Abraka, 21 August, 1991.

66. *Laws of the Colony of Lagos Vol.* I, p.3.

Table V

Vaccination Against Smallpox in Various Districts, Warri Province, 1906-1910, 1929

District	No of Vaccinations by years					
	1906	1907	1908	1909	1910	1929
Forcados	423	819	323	389	788	n.a.
Warri	1318	1139	1155	1140	2429	n.a.
Sapele/Kwale	2717	3747	1539	2256	2783	n.a.
Aboh	1220	755	1194	563	475	n.a.
Total	5678	6460	4211	4348	6475	6597

Note: n.a. means not available

Sources: Annual Report, Southern Nigeria, 1906, p.298; Annual Report, Southern Nigeria, 1907, p.327; Annual Report, Southern Nigeria, 1908, p.149, Annual Report, Southern Nigeria, 1909, p.2; Annual Report, Southern Nigeria, 1910, p.551; NAI, CSO 26/2/11857 vol. VIII: Annual Report, Warri Province, 1929, p.79.

Vaccination rarely extended beyond the townships and district headquarters. Usually vaccinators toured villages adjacent to their stations and would render their services to more distant rural communities only during outbreaks of smallpox or other epidemic diseases there. In 1928, for example, the government sent a vaccinator to Ogume to attend to smallpox patients.[67] The following year, more serious outbreaks of the disease occurred in rural areas of Warri, Kwale and Forcados and Ase Districts, thus intensifying the activities of government vaccinators.[68] The high figures recorded in vaccination returns shown in table V above indicate a high rate of activity during such periods.

67. Annual Report, Warri Province, 1928, p.66.

68. Annual Report, Warri Province, 1929, pp.79-80.

Through sporadic vaccination tours in outlying areas and the provision of free medical treatment for government and other workers, the Delta peoples gradually became acquainted with modern medical techniques. The tours provided a precedent that fostered future demands for expanded facilities. Furthermore, education further enhanced popular demands. Emerging problems stemmed from discrimination rooted in the racist ideology of colonialism. Its manifestation and other discriminations in the Warri Province were, however, minimal. First, the Europeans could obtain treatment as outpatients in African Hospitals, but indigenes could not receive treatment in European Hospitals.[69] Second, government workers, prisoners and certified paupers got free medical treatment from the African Hospitals while non-government workers paid hospital bills.[70] Thus, J.C. Caldwell's assertion that colonial medical services concentrated on the whites until the First World War requires modification.[71] Evidence in the annual reports shows that a significant amount of provincial medical officers' time was devoted to treating Africans. The African Hospitals, the Quarantine station and

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69. Interview, F.O. Esiri, Aged 81, Medical Officer 1937-1950, in Private Practice since 1951, Warri, 2 February, 1993.

70. *Ibid.*, Annual Report, Warri Province, 1926, p.62; Nigeria, Government Gazette No. 265, Rule No. 6 of 1906, Hospital Proclamation No. 7 of 1903, p.338.

71. J.C. Caldwell, "The Social Repercussions of Colonial Rule: Demographic Aspects" *UNESCO General History of Africa Vol. II, Africa Under Colonial Domination 1880-1935* ed. Adu Boahem. (London: Heinemann Educational Books, 1980), p.477.

the dispensaries at the district headquarters, opened in 1906, do not constitute "emergency measures". Rather they represent the first phase of popularising modern medical techniques in Warri Province.

Local Response to Colonial Health Policies and Institutions

Having surveyed the medical and health work of the colonial administration in the Warri Province between 1906 and 1929, we now examine the reception of new health policies and measures by the various Delta peoples. Since medical facilities concentrated in the townships, with only smallpox vaccination reaching the rural communities, our discussion focuses on local attitudes to new measures and opportunities. Rural dwellers comprised the bulk of the indigenous population. By and large, they gained little initial exposure to modern ideas except through Christian missions and primary schools in comparison to towns people who acquired greater exposure through Christian conversion, modern employment and education. The degree of enlightenment and exposure to new ideas influenced the greater acceptance of modern medical services by these groups of Delta people.

Available statistics on the number of hospitalized patients in the African Hospitals tabulated below (Table VI) indicate the initial low response to hospital services.

Table VI
Attendances in African Hospitals 1909-1929

Year	Warri		Sapele		Forcados	
	No. of Patients		No. of Patients		No. of Patients	
	Male	Female	Male	Female	Male	Female
1909	95	12	21	1	131	2
1910	95	12	80	8	214	6
1911	379	11	44	11	206	10
1919	291	25	75	3	180	15
1920	373	73	137	4	229	17
1921	276	34	120	10	21	-
1927	522	131	145	15	197	48
1928	793	186	205	21	200	18
1929	599	144	149	22	208	28

Sources: *Blue Book*, Southern Nigeria, 1909, pp. DD 19, 25, 27; *Blue Book,* Southern Nigeria, 1910, pp. DD 14, 18, 20; *Blue Book,* Southern Nigeria, 1911, pp. DD. 18, 23, 26; *Blue Book*, Nigeria, 1919, p. DD 10; *Blue Book,* Nigeria, 1920, Section 26, p. 15; *Blue Book,* Nigeria, 1921, Section 26, p. 15; *Blue Book,* Nigeria, 1927, Section 26, pp. 568; *Blue Book,* Nigeria, 1928, Section 26, p. 598; *Blue Book,* Nigeria, 1929, Section 26, p. 594

The table reveals a growing incidence of hospital treatment with men taking advantage of treatment more readily than women. The initial very low attendances reflected the small size of the new social groups that had adopted Western ideas. Knowledge about the effectiveness of modern medicine passed through them to other indigenes who started to accept modern medical procedures as the years progressed. Early apathy to modern methods gradually changed as the African work force grew. The government and companies offered free modern medical

treatment to workers and their families. In like manner, the increase in the number of Western Educated elite later promoted acceptance of the efficacy of modern medicine. In an African traditional society, decisions about a patient's treatment involved the entire family. As families acquired education and got wage earning kin, elders and others sought their views on modern sanitation and health practices. In cases where family members had joined the sanitary and medical professions familiarity and acceptance of new techniques progressed rapidly.

The wide gap between the number of male and female hospitalised patients can be understood from the low proportion of women among the social groups that initially accepted modern medicine. Only very few parents sent their daughters to school during this early period. In 1906, only sixteen percent of the pupils in all the schools in the province were girls.[72] Women were rarely employed as civil servants in the province within this period except for a few wardresses and teachers. Men still outnumbered them in these occupations.[73] Most likely the female patients enumerated in Table VI were wives of civil servants, missionaries or teachers.

The Delta peoples readily accepted modern treatments for illnesses they proved more effective than traditional methods. A medical report in 1906 remarked that the local population had recognised the importance of surgery.[74]

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72. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.210.

73. See Table VIII for proportion of Male and Female Wardresses in Hospitals in Warri Province; LaRay Denzer, "Yoruba Women: A Histographical Essay". *The International Journal of African Historical Studies* 27 (1), 1994, p.26.

74. Nigeria, Government Gazette May-December 1906 Vol. I, Medical Report, p.21.

This is in keeping with an observation made in Lagos that:

> Surgical Diseases form the greater number of cases the Natives have applied for treatment but on the whole the people are getting to understand the scientific methods of treatment which they could get at the hospital and therefore they are now less reluctant in bringing their cases and seeking advice than heretofore.[75]

The precision with which modern medical doctors "removed" diseases through a surgical operation impressed everybody undergoing the experience.[76] Although claims abounded concerning the ability of traditional healers to undertake complicated operations, modern medical procedures proved more effective and surpassed the expertise of traditional healers.[77]

The process governing the choice between modern medicine and traditional methods in the management of diseases depended on a variety of cognitive and empirical factors. The Delta peoples became experienced in judging which system was more likely to provide an efficacious treatment. When, for example, a patient's illness defied treatment in a hospital, his relatives quickly removed him, believing that his malady might have a metaphysical causation and required treatment by traditional healers.[78] Official records, however, referred to such patients as "helpless cases".[79] Until the effectiveness of modern medicine or

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75. Annual Report, Lagos Colony, 1903, p.43.

76. Interview, Esiri.

77. J.O. Ubrurhe, "Urhobo Traditional Medicine", p.170.

78. Interview, David Enaworu, Aged 51, Traditional Healer/Witch Doctor, Abraka, 15, November, 1990.

79. NAI, CSO 26/2/11857 Vol. X: Annual Report, Warri Province, 1932, p.64.

procedures in the cure or control of diseases became established the Delta peoples maintained a healthy scepticism. In 1906 a medical report noted that "the natives... are beginning to appreciate the benefits of vaccination".[80] From that time, the number of vaccinations in each district remained high throughout the period except where services lapsed as in Aboh district. By the end of 1929, smallpox vaccination had significantly lowered the incidence of outbreaks of the disease in the towns. Only two, six and eight cases of smallpox were recorded at Warri, Forcados and Burutu, respectively with only two deaths in Forcadoes, one in Burutu and none in Warri. There was no case at all in Sapele that year.

In the rural communities, however, the incidence of smallpox remained very high. In the same year (1929), there were 137 cases and 33 deaths in the Ase sub-district and forty cases with eleven deaths in Kwale District.[81] Except for rural communities bordering the towns, vaccination exercises reached these distant rural areas only during serious outbreaks of smallpox and other endemic diseases. Most communities saw the vaccinators for the first time within such periods and therefore were reluctant to submit themselves for treatment. In 1928, for example, during an outbreak of a disease suspected to be smallpox, a medical team travelled to Ogume but the patients refused to come forward for treatment.[82]

The following year another outbreak of smallpox occurred among the rural communities in Kwale and Forcados districts as well as in Ase sub-district. It

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80. Annual Report, Southern Nigeria, 1906, p.331.

81. Annual Report, Warri Province, 1929, pp.79-80.

82. Annual Report, Warri Province, 1928, p.66.

resulted in thirty-three deaths in Ase, eleven in Kwale and nine in Forcados districts.[83] The medical officer stressed that "the general reluctance of women to be vaccinated constitute(d) a danger".[84] Thus rural women like their sisters in the towns, demonstrated a conservative force discouraging quick acceptance of new methods. Their reasons were similar to those advanced earlier.

Another modern measure introduced to rural communities involved the use of quinine as a prophylaxis against malaria. When Dr. Darker, the Medical Officer of Sapele, popularised the sale of quinine to villages within Sapele town and within a five mile radius, he reported a twenty-five percent response.[85] This impressive response by these villagers stemmed from their close interaction with the town dwellers and the fact that government propaganda concerning modern health care reached them directly. Rural communities outside this zone did not benefit from such privileges hence they remained sceptical to the use of modern medicine within this period.

Scepticism about Western preventive and curative measures meant that often infected persons waited too long before seeking modern treatment, perhaps only after traditional measures had failed. Doctor F. Esiri observed that most patients reported so late to the hospitals that it was impossible to rescue them.[86]

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83. Annual Report, Warri Province, 1929, p.80.

84. Ibid.

85. Annual Report, Colony and Protectorate of Southern Nigeria, 1906, p.331.

86. Interview, Esiri.

The major reasons for the slow acceptance of modern medicine by the rural dwellers were lack of facilities and propaganda. These became available to the town dwellers from 1906 when the medical and health institutions were established. Only after the fatal outbreaks of smallpox in the rural districts in 1929 did the provincial authorities start to contemplate on carrying out enlightenment campaigns to the rural communities.[87] In fact, colonial medical and health policy within this period did not include the rural areas. The sporadic attempts at disease control during serious outbreaks of diseases in rural communities had the purpose of controlling the spread of such diseases to the towns.

Because of lack of education through enlightenment campaigns initial vaccination exercises sparked off speculations in the villages. A notable one being that the British intended to extract their blood during the process of vaccination in order to impede the physical and mental development of the victims especially the healthy ones who were also invited for vaccination. This speculation looked very plausible in view of the encounters these communities had with the colonial troops during the pacification period.[88] Unfortunately, the Western educated citizens and wage labour force that could have helped to counter the speculation in the absence of government propaganda were relatively limited in number because they lived mostly in towns. Only school and Church teachers lived in communities that had schools and Churches.

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87. Annual Report, Warri Province, 1929, p.80.

88. Interview, D. Osani, Aged 45, Lecturer, Abraka, 5 February, 1993.

Furthermore, the experience of severe reactions to European drugs and methods after the initial vaccination exercises discouraged other people. Many people feared the deep knife cuts for the administration of vaccines. Even when the vaccinators changed to using needles to puncture holes for the vaccines the fear did not subside. This process coincided with the traditional process of immunisation against poisons, witchcraft, and other physical and metaphysical forces during which time knife cuts were made before applying the concoctions and therefore should not have scared the Delta peoples. But there was a difference. Many people reacted to vaccinations. The after effects included high fever, severe headache and sores. These did not occur after traditional processes.[89] In fact, the similarity between modern vaccination methods: the introduction of vaccines into the blood vessels to render people immune to attacks of certain diseases, and the traditional method of introducing concoctions into the body to neutralise some physical and metaphysical attacks by enemies eventually fostered the mass acceptance of vaccination. That happened in later periods after facilities were provided, adequate campaigns carried out and people experienced the efficacy of vaccinations.

Assessment of Policy

At this juncture we can attempt an assessment of the colonial medical and health services within this period with a view to highlighting successes and failures in policy implementation. The years 1906-1929 represented a foundation period in the development of modern medical and health services in Warri Province.

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89. Interview, D. Osani, Aged 45, Lecturer, Abraka, 5 February, 1993.

Separate conventional hospitals for Africans and Europeans were founded in the major towns (Warri and Sapele) and another African hospital at Forcados. These towns also had infectious disease hospitals whereas dispensaries served other smaller towns and district headquarters. These hospitals no doubt attended to the medical needs of the European communities, government workers, prisoners and other Delta indigenes that availed themselves of the services they provided through their in-patient and out-patient facilities. Table VII shows that most hospitalised patients recovered, many got relief, a few died while very few did not improve.

Table VII
Admissions and Discharges in Hospitals 1911-1929

Year	No Admitted		No Cured		No Relieved		No Not Improve		No Died	
A	African Hospital Warri									
	M	F	M	F	M	F	M	F	M	F
1911	379	11	297	5	59	2	7	-	14	4
1919	291	25	253	15	14	4	3	2	21	4
1921	276	34	238	24	6	-	-	-	28	10
1926	536	114	462	92	25	6	12	3	24	9
1929	599	144	437	79	112	33	13	14	27	18
B	African Hospital Sapele									
1911	44	11	34	4	3	2	2	2	2	3
1919	75	3	60	2	7	-	-	-	10	-
1921	120	10	94	7	4	-	15	1	11	2
1926	173	18	122	10	18	4	9	2	14	2
1929	149	22	128	21	2	1	-	-	13	1
C	African Hospital Forcados									
1911	206	10	102	2	98	6	10	2	9	-
1919	180	15	170	14	7	1	3	-	3	-
1921	21	-	18	-	11	-	1	-	-	-
1926	139	16	132	15	-	-	-	-	12	-
1929	208	28	150	20	46	2	4	1	5	-
D	European Hospital Warri									
1911	42	-	41	-	-	-	-	-	1	-
1919	55	2	50	1	3	1	-	-	2	-
1921	31	1	32	1	2	-	-	-	-	-
1926	59	6	56	6	1	-	-	-	-	-
1929	57	3	52	3	4	-	-	-	1	-
E	European Hospital Sapele									
1911	53	-	6	-	37	1	-	-	-	-
1919	15	-	12	-	2	-	1	-	1	-
1921	18	-	13	-	1	-	1	-	3	-
1926	No longer in the list of hospitals									
1929	No longer in the list of hospitals									

Sources: Blue Book, Southern Nigeria, 1911, pp. DD 18, 23, 26; Blue Book, Nigeria, 1919, p. DD 10; Blue Book, Nigeria, 1921, Section 26, p. 15; Blue Book, Nigeria, 1926, Section 26, p.539; Blue Book, Nigeria, 1929, Section 26, p.527.

Nevertheless these hospitals suffered from an acute shortage of personnel at all levels. Only one medical officer served in the two hospitals in each town throughout the period (1906-1929), except for Warri where a second medical officer assisted the Chief Medical Officer in-charge of the province. It was a pathetic situation as the lone doctors had the responsibility for paying regular monthly visits to other health institutions in the division in addition to administrative duties. Inevitably, lapses did often occur. Most of the time they could not inspect other medical institutions and when they did the urban hospitals remained without doctors for the period in which they stayed away.[90]

Neither did the situation in nursing staff shown in Table VIII improve much in 1929 except for the Warri African hospital. The Blue Book figures used here are even higher than those in the Annual Reports.[91] Yet in most hospitals, except with the help of hospital servants, one qualified nurse worked for a whole day while another took the night shift. For most of the period only one worked at the Forcados African Hospital each time, with the result that no nurse worked night shifts. The Sapele hospitals (European and African) employed no nurse at all. throughout 1911. Men dominated the nursing profession to the extent that except for two years (1926 and 1929) in Warri hospital and one year (1921) in the Sapele African hospital, no female nurses took night shifts. On the whole, the staffing situation for nurses fell far below the standard required in colonial hospitals at the

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90. Annual Report, Warri Province, 1929, p.79.

91. *Ibid.*

Table VIII

Nursing Staff in Hospitals 1911, 1919, 1921, 1926, 1929

A: African Hospital Warri

Year	Day Nurses		Night Nurses		Hospital Servant	
	Male	Female	Male	Female	Male	Female
1911	1	1	1	-	-	-
1919	4	2	1	-	7	-
1921	4	2	1	-	8	-
1926	7	2	2	19	-	-
1929	9	3	2	1	21	-
B. African Hospital Sapele						
1911	-	-	-	-	-	-
1919	1	-	-	-	1	-
1921	1	1	1	1	1	-
1926	2	1	-	-	3	-
1929	2	1	2	-	4	-
C. African Hospital Forcados						
1911	1	-	-	-	1	-
1919	1	-	-	-	-	-
1921	1	-	1	-	1	-
1926	1	-	1	-	1	-
1929	1	-	-	-	1	-
D. European Hospital Warri						
1911	1	2	-	-	-	-
1919	2	-	1	-	5	-
1921	2	2	1	-	5	-
1926	2	1	1	-	4	-
1929	2	-	1	-	7	-
E. European Hospital Sapele						
1911	-	-	-	-	1	-
1919	1	-	1	-	1	-
1921	1	-	1	-	1	-
1926	No longer in the list of Hospitals					
1929	No longer in the list of Hospitals					

Sources: Blue Book, Southern Nigeria 1911, pp. DD 18, 23, 26; Blue Book, Nigeria 1919, p.DD 10; Blue Book, Nigeria, 1921, Section 26, p.15; Blue Book, Nigeria, 1926, Section 26, p.539; Blue Book, Nigeria, 1929, Section 26, p.527.

time. According to the rules for nurses, a nurse should work twelve hours (between 6 a.m. and 6 p.m.) when on day duty and not more than three hours at night duty.[92] Most of the time only one nurse worked in a night, meaning that the lone nurse worked the whole night. There is no doubt that the scarcity of medical personnel, both doctors and nurses, impeded effective implementation of medical and health policies of the colonial government in the Warri Province between 1906 and 1929.

Public health services in this early period centred on campaigns against the common endemic diseases especially malaria and smallpox, disposal of human and other wastes and improving the water supply. By 1929, the administration had achieved significant success in implementing preventive measures against malaria and smallpox in the towns. For example, the sanitary report of 1913 indicated a fall in mosquito index from 11.0 in 1911 to 5.06 in 1912 and 3.77 in 1913. In the opinion of the Medical Officer, Lionel Hethorn Booth, the index would have been smaller if they excluded rural areas where sanitary work had not begun.[93] The number of cases of smallpox in the towns in 1929 suggests successful control of disease environment. Two cases occurred in Warri, six in Forcados, eight in Burutu and none in Sapele, resulting in no fatality in Warri, two deaths in Forcados and one in Burutu.

The administration, however, achieved little or no success in wastes'

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92. Colony of Lagos, Government Gazette, Rules for Native Nurses, 1897, p.375.

93. Annual Report, Southern Nigeria, 1913, p.17.

disposal and improving the water supply. Apart from installing water catchment facilities in European quarters, provision of pure water supply did not materialise at all. The traditional sources of water supply, river, stream and collection of rain water still remained the main sources. Likewise the few public latrines instituted in the towns did not satisfy the needs of the growing population. Because of inadequate maintenance many people tended to fall back to their old habits of indiscriminate defecation and urination.

A major problem that inhibited successful implementation of medical and health policy arose from inadequate funding. At this stage of colonial rule all social and economic programmes received the least attention from the colonial state for two main reasons. First, attention focused on establishing and sustaining British rule by force as well as exploiting the economic resources of the colonial territory. Therefore, emphasis centred on programmes that facilitated these objectives. Hence the maintenance of the West African Frontier Force and projects and programmes related to transportation (Railway, Marine and Public Works), got allocations amounting to between thirty-six and fifty percent of the national income during this period. Social and economic services and programmes received between five and twelve percent of the national expenditure. Table IX reveals the disparity in figures between the West African Frontier Force and health and medical services.

The Health ministry even received priority attention over all other social and economic services ministries. Since it attracted greater share of budgetary

Table IX

National Expenditure on Health, All Socio-Economic Services, West African Frontier Force, Railway, Marine and Public Works 1920-1929

	Medical and Health Services		West African Frontier Force		Railway, Marine & Public Works (Together)		Health, Education Agriculture & Forestry (Together)	
Year	Amount £	percent	Amount £	percen	Amount £	percent	Amount £	percent
1920	222661	3.42	350254	5.39	2906718	44.76	388804	5.98
1921	257610	3.59	468176	6.52	2964886	41.33	404924	5.64
1922	257610	3.59	468176	6.52	2944686	41.05	434924	6.06
1923	257976	3.92	350319	5.33	2063577	31.43	450957	6.86
1924	261524	4.71	327449	5.9	1856623	33.48	472432	8.52
1925	259146	4.22	345705	5.63	2161336	35.22	485390	7.9
1926	304805	3.92	344300	4.43	2577878	33.21	541147	6.97
1927	354029	4.66	361183	4.75	3222252	44.42	655421	8.62
1928	434025	6.12	343919	4.85	2659879	37.53	794966	11.21
1929	473137	6.13	359728	4.79	2506576	33.44	897122	11.96

Sources: *Nigeria Blue Books* 1920-1929, Section 2
Note: Calculation of percentages and additions were done by the author.

allocations. Allocations to Education, Agriculture and Forestry shown in Table X bring out more glaringly the degree of neglect of social and economic programmes during this period.

The second reason for the poor funding of health and other social services centered on the unwillingness of the British government to assist its colonies in their development programmes because of its doctrine of self-sufficiency. The doctrine dictated that all social and economic development programmes in a colonial territory should be financed through internally generated revenue.[94] Consequently, social services in poor colonies like Nigeria suffered serious neglect within this period. Whereas Ghana's annual per capita expenditure for medical and health services during this period amounted to two shillings, Nigeria's per capita allocation to this sector stood at five pence.[95] In 1944, the Director of Medical Services in Nigeria, J.W.P. Harkness, admitted that Nigeria's allocation to medical, and health services before 1945 was the lowest in the British Empire.[96]

Before 1930, however, the colonial state and the British government had realised their poor performance in developing social services in Nigeria and therefore started to reformulate their policies. Having laid a foundation for health

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94. M. Crowder, *West Africa Under Colonial Rule* (London: Hutchinsn and Co., 1968), p.503.

95. Caldwell, "The Social Repercussions of Colonial Rule" p.477.

96. *A Ten Year Plan of Development and Welfare for Nigeria: Paper Laid on the Table of the Legislative Council on 13th December 1945 as Sessional Paper No. 24 as Amended by the Select Committee of the Council and Approved by the Legislative Council on 7th February 1946* (Lagos: Government Printer, 1946), p.68.

Table X

National Expenditure on Medical and Health Services, Agriculture, Education and Forestry 1920-1929

	Medical and Health		Education		Agriculture		Forestry	
	Amount		Amount		Amount		Amount	
Year	£	percent	£	percent	£	percent	£	percent
1920	222661	3.42	69443	1.06	32751	0.5	63947	0.98
1921	257610	3.59	87494	1.21	36555	0.09	53264	0.74
1922	257610	3.59	87494	1.21	36555	0.5	53264	0.74
1923	257976	3.92	100063	1.52	41072	0.62	51844	0.78
1924	261524	4.71	109202	1.96	48972	0.88	52732	0.95
1925	259146	4.22	116301	1.89	55094	0.89	54847	0.89
1926	304805	3.92	125250	1.61	62202	0.8	56887	0.73
1927	354029	4.66	158453	2.08	80058	1.05	62899	0.82
1928	434025	6.12	198837	2.8	94638	1.33	67464	0.95
1929	473137	6.31	232594	3.1	119052	1.58	72335	0.96

Sources: *Nigeria Blue Books* 1920-1929 section 2
Note: Calculation of percentages wer done by the author.

and medical services in the towns they started developing programmes for consolidating and expanding such services to rural dwellers who constituted a greater percentage of the population but did not benefit from the medical and health services rendered during this period. The Governor of Nigeria, Sir Graeme Thomson, introduced taxation to the "untaxed provinces" which included the Warri Province to generate funds for the Native Administrations which were expected to supplement the efforts of the colonial administration towards providing social services. He stressed the need to

> Stimulate local patriotism and initiative by the recognition of the Native Administrations as partners of Government in the general task of developing the country.[97]

In 1927, he also proposed to the Secretary of State for the colonies a system of grants-in-aid to missions for their medical work in Nigeria.

The British government also took steps to change its policy on development programmes in colonial territories. In 1926, it delegated the Parliamentary Under Secretary of State for the colonies, W.G.A. Ormsby Gore, and the newly appointed adviser to the Secretary of State for the Colonies on health services, Dr. A.T. Stanton, on different occasions, to survey the state of health services in West Africa and make recommendations.[98] Consequent upon

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97. S. Phillipson, *Administrative and Financial Procedure Under New Constitution between Government of Nigeria and the Native Administrations* (Lagos: Government Printer, 1947), pp.54-55.

98. Great Britain, Cmd 2744 p.75: Ormbsy Gore's Report on Public Health in W.A. Sept. 1926; Great Britain, Cmd 3268 p6 A.T. Stanton's Report on Public Health W.A. Dec. 1926.

their recommendations the British Labour government of Ramsay MacDonald decided, in 1929, to give a grant of £1 million a year to Nigeria from 1930 to supplement her budgets.[99] Details of these new moves and their impact on the development of medical and health services in Warri Province belong to, and will be discussed in the next chapter.

99. Schram, p.314; Charles Lock Mowat, *Britain Between the Wars* (London: Methuen, 1955), pp.353 and 382.

CHAPTER THREE

EXPANSION OF URBAN, AND INSTITUTION OF RURAL MEDICAL FACILITIES 1930-1944

Reforms and Colonial Medical Policy

Towards the end of the 1920s the British Imperial Government and the colonial state independently initiated new socio-political reforms which enhanced the expansion of urban medical facilities and the institution of medical policy in the rural areas after 1929. In 1926, the British Government appointed Dr. A. T. Stanton:

> To advise the Secretary of State generally on all medical and sanitary matters in the colonies and protectorates... To ensure continuity of policy, co-ordination of action between different administrations and the introduction of new ideas in the work of the Colonial Medical Services.[1]

That same year, the Under Secretary of State for the colonies, W.G.A. Ormsby Gore, toured the West African colonies to survey the state of socio-economic development programmes including medical and health services. Between February 4 and March 19 he toured most provincial headquarters and towns in Nigeria inspecting social and economic institutions and held consultations with both officials and non officials. He observed that medical and health services in Nigeria compared unfavourably with other West African colonies. Ghana with a population of two and a half million had twenty-five African hospitals with 644 beds while Nigeria with a population of nineteen million, had only twenty-one

1. Great Britain Cmd 3268 p.6: A. T. Stanton's Report on Public Health in WA December, 1928.

African hospitals with 636 beds. He also observed a general lack of equipment, drugs and dressings in the existing hospitals. He ascribed the backward situation in Nigeria mainly to "financial stregency" and recommended the improvement of existing facilities through adequate provision of equipment, drugs and dressings. He stressed the need for the government to provide medical and health services for the entire 'native' population unlike in the past when it concerned itself with services to European and "native" officials, and emphasised the training of indigenous Dispensers and Dressers to undertake health services among their people especially within their ethnic groups.[2] Similarly, indigenous midwives and welfare workers should be trained to institute maternal and child welfare services to their people.[3]

Two years later, Dr. Stanton toured the West African colonies to follow up Ormsby Gore's investigation spending one month in Nigeria (16th August to 15th September) surveying health and medical facilities. He underscored the previous recommendations for expansion of health services.[4] These two official reports emboldened the more sympathetic Labour Government of Ramsay MacDonald which came into power in 1929 to pass the Colonial Development Act of 1929 providing a grant of one million pounds to support Nigeria's annual budget from

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2. Great Britain Cmd 2744pp.73-76, 187-188: Ormsby Gore's Report on Public Health in WA and his Itinerary. Sept. 1926.

3. Ibid, p.76.

4. Great Britain Cmd 3268p.26: A.T. Stanton's Report on Public Health in WA December 1928.

1930.[5] This act marked a turning point in imperial policy by providing fund to support the expansion and institution of social and economic programme in a colonial territory. Although the economic depression of the 1930s made it difficult for Britain to implement the provisions of the Act, nevertheless it advanced annual grants ranging from £2,605 to £265,699 between 1930 and 1944 as shown in Table XI below.

Table XI
Grants from Colonial Development Fund to Nigeria 1930-1944

Year	Grant in Pounds
1930/1931	2,605
1931/1932	28,016
1932/1933	40,908
1933/1934	25,374
1934/1935	14,489
1935/1936	17,739
1936/1937	17,342
1937/1938	69,500
1938/1939	18,088
1939/1940	15,075
1940/1941	12,625
1941/1942	18,542
1942/1943	57,841
1943/1944	76,714
1944/1945	265,699

Source: Annual Report, Nigeria, 1945-46, p.91.

In Warri Province grants from this fund facilitated the limited expansion of sanitary measures and control of endemic diseases.

In Nigeria reforms in the Native Administration system, which had been

5. Mowat, *Britain Between the Wars*, p.353; Schram, History of Nigerian Health Services, pp.314-315.

operating in the Northern and Western provinces (except Warri) were extended to the Warri and the Eastern Provinces. The Native Administrations had become the agency for the expansion of governmental social services including health services, in the areas where they operated. In 1927, Governor Graeme Thomson abolished the Warrant Chief system, inaugurated the Native Administration system and embarked on re-organising the Warri Province, setting up Aboh, Sobo (Urhobo), Ijo and Sobo-Jekri (Itsekiri) divisions or NAs.[6] He also introduced, for the first time, taxation to Warri and the Eastern provinces to generate revenue for social services. Though a series of anti-tax riots immediately followed, the government quickly re-established civic stability and successfuly collected taxes the following year. Financial policy dictated that fifty percent of the revenue derived from taxation and court fines be paid into the Native Treasury for local development and public services.[7] This canalised funds into a programme for exapanded social services, including medical services.

Also in 1929, the Governor's proposal on a system of grants-in-aid to assist the Christian Missions in their medical work in Nigeria got the approval of the Secretary of State for the Colonies. This resulted in regular grants to the missions from 1929 as shown in Table XII below.

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6. NAI, CSO 26/2/11857 Vol. X: Annual Report, Warri Province, 1932, pp.17-18.

7. Ikime, *Niger Delta Rivalry*, pp.221-228.

Table XII
Grants-in-Aid of Mission Medical Work, Nigeria 1929/30-1944/45

Year	Grants in Pounds	
	General	Leprosy Control
1929/30	6,000	4,776
1930/31	3,000	4,000
1931/32	500	4,000
1932/33	500	3,760
1933/34	1,000	3,550
1934/35	1,500	2,500
1935/36	1,500	2,700
1936/37	2,400	2,700
1937/38	2,600	3,500
1938/39	2,600	5,000
1939/40	1,265	5,000
1940/41	780	4,000
1941/42	780	5,200
1942/43	780	5,200
1943/44	400	11,000
1944/45	400	11,000

Source: Sydney Phillipson (Appendix D), *Report on Grants-in-Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria* (Lagos: Government Printer, 1949), p.55.

Although financial assistance to the missions remained minimal and dwindled over the years, it enabled the CMS Niger Mission to expand its maternity and childwelfare programme to Warri Province in 1930,[8] while the Catholic Mission took responsibility for the management of the Ossiomo Leprosy Settlement established by the NAs with direct grants from the government. Thus, the missions and the NAs became the main organs for the institution of medical services in rural areas.

8. Sydney Phillipson, *Report on Grants-in-Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria* (Appendix D), Lagos: Government Printers, 1949), p.55.

At the Residents' Conference of 1929 the government significantly revised its public health policy on the basis of Ormsby Gore's recommendations. They endorsed recommendations for the expansion of the network of dispensaries and the training of dispensers. The government scheduled the official launching of the scheme of NA dispensaries for 1930.[9] Consequently, the provincial authorities in Warri proposed to build dispensaries in the Ase, Sapele and Kwale Districts in preparation for the launching.[10]

Within this period the urban social groups oriented towards Western medical ideas and who engineered the acceptance of modern medicine by their relatives and friends in the rural areas had grown much higher through the expansion of Western education. By 1944 the number of NA, mission and government schools in the province had risen to 125.[11] The province had also established a number of post-primary and other institutions including a NA teacher training college (Warri), two commercial schools (Warri and Sapele), a CMS teacher training college (Oleh), eight adult education classes (Warri) and Rural Women Education Centres (RWEC) at Ughelli and most Urhobo clans.[12]

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9. Nigeria, Department of Medical and Sanitary Service, Annual Report, 1929, p.12.

10. NAI, CSO 26/2/11857 Vol. VII: Annual Report, Warri Province, 1929, p.80.

11. NAI, CSO 26/2/11857 Vol. XVIII: Annual Report, Warri Province, 1941 Onwards (1943), p.7.

12. NAI, CSO 26/2/11857 Vol. IX: Annual Report, Warri Province, 1931, p.86; Vol. XVI: Annual Report, Warri Province, 1939/1940 (1939), p.21; Vol. XVIII: Annual Report, Warri Province, 1941 Onwards, (1941), p.4; (1943), p.11; (1944), p.9.

Christianity had as well taken root in the remotest parts of the province.[13] With the growing involvement of the missions in medical work propaganda against traditional healing methods intensified. The missionaries encouraged modern medical methods through instruction in the RWEC and other organisations within the Church.[14] Towards the end of the period covered by this chapter the educated elite, clan and tribal unions mounted pressure for the increased medical facilities, while in addition, editors of newspapers criticised slow implementation of public health policy.[15]

This chapter will examine the impact of these new programmes and pressures on the expansion of existing facilities and institution of medical and health services in the rural areas in the Warri Province between 1930 and 1944.

B. Implementation of Policy in Warri Province: Expansion of Provincial Infrastructure and Programmes

(1) Hospitals: The provincial authorities augmented existing facilities in the townships. In 1930, they built a new operating theatre at the African Hosptial, Sapele and five years later established a female ward in the reconstructed

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13. Erivwo, *History of Christianity in Nigeria*, pp.27-103.

14. Annual Report, Nigeria, 1921 (Lagos: Government Printer, 1922), p.72.

15. See Editorial Comments in the Southern Nigeria Defender 20,21,24,25,28 January; 26 November; 27 December 1944, all page 2. These demand more hospitals, improvement of medical facilities and complain of understaffing among other issues. See also demands by individuals such as J.E. Ogboru, T.T. Unchendu, Francis Oputa, F.M. Ikomi, Joseph Okitikpi, *Southern Nigeria Defender*, April 3,p.2; March 7, p.1; May 29, p.1; April 15, p.1, 1944.

government school building, increasing the number of beds from eighteen to thirty-one.[16] Furthermore, they improved the working environment of the hospital staff by the provision of a Sister's Duty Room and a covered way from the Sister's bungalow to the African hospital Warri offering protection from the rain.[17]

(2) Sanitation: In the area of sanitation, the administration extended existing measures to the industrial areas in the province in compliance with section two of the Labour Ordinance of 1929 which provided that medical officers and a senior sanitary superintendent should inspect designated Labour Health Areas regularly.[18] From 1938, these officers started inspecting the United African Company's Bulk Oil Plant and Transport Depot (Burutu), Messrs Millers Brothers Rubber Plantation (Sapele), the United African Company's Palm Oil Plantation (Ajagbodudu), and the James Thomas Rubber Estate, Sapele.[19] The Resident Warri Province, Mr. Robert Leonard Bowen assessed the impact of the inspection

16. Nigeria, Department of Medical and Sanitary Service, *Annual Report*, 1919-1921, p.27, CSO 26/2/11857 Vol. VIII: Annual Report, Warri Province, 1930, p.229; Vol. XII: Annual Report, Warri Province, 1935, p.17.

17. Warri Province, Annual Report, 1930, p.229.

18. NAI, CSO 26/2/11857 Vol. XVI: Annual Report, Warri Province, 1939/40, Enclosure p.39, p.19.

19. NAI, CSO 26/2/11857 Vol. XV: Annual Report, Warri Province, 1938, pp.41-42.

of the Senior Sanitary Superintendent, Mr. James Youngson Brown as follows:

> He has travelled extensively and taken mosquito indices in various centres and introduced anti-amrl measures. At Burutu after a mosquito survey, in collaboration with the Health Department the Traffic Manager United African Company instituted routine inspection and mosquito disinfectation of all the United African Company's river craft between Burutu and the interior... Mosquito surveys have also been taken at the various labour estates and measures introduced to prevent breeding.[20]

He succeeded in enforcing laws in the Labour area. The management of the UAC acknowledged the eradication of mosquitoes after the implementation of control measures and promised to make funds available for further sanitation purposes.[21]

With grants from the Colonial Development Fund the provincial administration initiated the expansion of sanitary measures into few rural communities. In 1934, a grant of fifty-six pounds enabled it to construct public latrines containing eight buckets each and incinerators at Ashaka and Obiaruku.[22] The Kwale NA employed labourers to service the latrines and dispose the nightsoil by "burying in shallow trenches a foot wide and a foot deep in the bush". The government vaccinator at Obetim Kwale, Mr. P. Aghagbon, inspected the public latrines as well as the disposal of the excreta twice a week.[23]

Colonial Development grants also facilitated the provision of potable drinking water for some communities. In 1931, the government sank a well with a

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21. Ibid, p.493; Annual Report, Warri Province, 1939/40, (1939), p.19.

22. NAI, Kwale Dist 1/344 pp.6,53,65: Resident Warri to DO Kwale 10-2-33, DO Kwale to Obi of Aboh 29-5-34, DO Kwale to Resident Warri, 22-8-34.

23. NAI, Kwale Dist 1/344 p.58: DO Kwale to Vaccinator 8-6-34.

hand pump at Warri prison.[24] The following year it sank two wells at Obetim Kwale and supplied washers and other spare parts for them in 1935.[25] The most elaborate scheme undertaken was a water scheme for Sapele township. A detailed description of the plan is as follows:

> The supply is arranged in units, each consisting of a concrete well 25 feet deep fitted with a Twin Cylinder Beck Pump and one 600 Gallon Galvanised Steel Tank. The tank is fitted with dia taps from which the water is drawn. The method of supply is to fill the tank at convenient intervals so that a continuous supply is available to the public.

Two such wells and their facilities, completed at the cost of ninety-three pounds each, came into use at Sapele in 1932, while two others opened for public use the following year.[26]

While the Sapele community welcomed the regular supply of water from these wells it rejected a suggestion by the Deputy Director of Health Services, Dr. George Blyth Walker, to install a piped water supply in Sapele in 1937 because of its high cost. According to Rev. A Omashola of the Baptist mission Sapele:

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24. NAI, Sap. 1/2/T.40 Vol. 1, p.34: J.H. Gillespie, Divisional Engineer to Resident, WP 30-5-31.

25. NAI, Kwale Dist 1/344p.2: Ag. DO Kwale to Resident Warri 10-9-32; NAI, Kwale Dist 1/141 Vol. III: Annual Report, Aboh Division 1935, p.28.

26. NAI, Sap Dist 1/2/T40 Vol. II pp.11,12 and 46, DO Sapele to Resident Warri 4-2-33, J.H. Gillespie, Divisional Engineer to LA Sapele (ND). Between 20-28/10/33.

> They all unanimously said that a scheme for an adequate water supply is needed in the Township, but they will not afford to pay water rate at any time as they are paying rent and rate on the plot occupied in the township besides the annual tax.[27]

(3) Propaganda/Education: The provincial authorities formulated enlightenment campaigns in the rural areas and also organised lectures for groups of teachers and students who were in the position to disseminate such teachings to the rest of the populace. In 1932, the Medical Department organised a series of lectures on sanitation and hygiene for students of Elementary Training College in Warri to assist them in preparing lessons for their pupils.[28] Four years later the medical officer of Warri, Greeme Mitchel Menzies, conducted short courses in simple medicine and dressing for school teachers to train them to treat their pupils in the absence of dispensary attendants.[29] Women's groups were also targeted. In 1938, Menzies organised lectures to students of the RWEC Ughelli and primary school pupils in Warri township.[30]

In addition, the medical officer of health, Dr. Rhys Caradoc Jones, conducted enlightenment campaign tours against smallpox in the Urhobo area between September and December 1932, resulting in the vaccination of 23,457 people.

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27. NAI, Sap Dist 1/2/T40 Vol. II p.106: Rev. Omoshola to LA Sapele 18-8-37.

28. Annual Report, Warri Province, 1932, p.53.

29. NAI, CSO 26/2/11857 Vol. XIV: Annual Report, Warri Province, 1936/37, p.436.

30. Annual Report, Warri Province, 1938, p.492.

during the exercise.[31] The government vaccinator at Obetim Kwale, Mr. P. Aghagbon, carried out a similar campaign in the Kwale division in 1933 and vaccinated 900 persons.[32] Such high response among the villagers indicated a positive level of appreciation of the value of immunisation against smallpox.

C. Control of Endemic Diseases

The provincial government, in collaboration with the Native Administrations, increased efforts to control the most prevalent endemic diseases in the province: smallpox, yaws, leprosy and malaria. Since a successful control of these diseases served to further popularise modern medicine and facilitate its acceptance.

(A) Smallpox:

In 1931, a medical census conducted in Nigeria uncovered the very high incidence of smallpox in the Warri province. A year later Dr. Jones' tour confirmed its prevalence. Over fifty percent of the men and forty percent of the women had contacted smallpox.[33] To counter the danger posed by such high incidence of contagion, the provincial administration intensified its campaigns against the disease through medical tours of towns and villages to treat smallpox as well as to administer vaccinations. We have already noted the success that attended tours in the Urhobo and Kwale Divisions in 1932 and 1933. Tables XIII to XVI below illustrate the continuing success of subsequent tours.

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31. Annual Report, Warri Province, 1932, p.64.

32. NAI, CSO 26/2/11857 Vol. XI: Annual Report, Warri Province, 1933, p.33.

33. Annual Report, Warri Province, 1932, p.64; J. Turner, *Census of Nigeria 1931 Vol. VI, Medical Census, Southern Provinces* (London: SW1, 1932), p.20.

Table XIII

Tours of Towns and Villages for Vaccinations Against Smallpox, Aboh Division, 1936

Towns/Villages	No. of Cases	No. of Deaths	No of Vaccinations
Utagbauno	1	0	530
Abbi	19	5	2204
Igbuku	2	2	201
Aboh	54	14	1096
Ashaka	3	2	375
Utagba Ogbe	4	1	494
Total	83	24	4900

Source: NAI, Kwale Dist. 1/141, Vol.IV: Annual Report, Aboh Division, 1936, p.27

Table XIV

Tours of Towns and Villages for Vaccinations Against Smallpox, Aboh Division, 1937

Town/Village	No. of cases	No of Deaths	No of Vaccinations
Abiayiafiako	7	1	37
Isala	3	0	103
Abragada	152	15	41
Eziokpor	6	2	274
Obiaruku	2	0	714
Ashaka	2	0	688
Ibrede	55	4	607
Okpai	137	14	1274
Umuolu	2	0	588
Onya	47	0	150
Utuoku	136	24	310
Abbi	1	0	414
Ossissa	4	0	2429
Total	554	60	7633

Source: NAI, Kwale Dist. 1/141, Volume V: Annual Report, Aboh Division, 1937, p.37

Table XV

Tours of Towns and Villages for Vaccination Against Smallpox, Aboh Division, 1938

Town/Village	No. of Cases	No. of Deaths	No. of Vaccinations
Aragba	1	-	474
Ase	15	3	460
Adiai Obiaka	3	1	221
Sanubi	1	-	175
Umukwata	1	-	1,081
Ogume	6	-	2,004
Aboh	5	1	424
Iyiowu	73	7	226
Ise-Ugbena	9	1	112
Oria-Abraka	1	1	501
Lagos-Iyede	9	1	433
Prison-Kwale	18	-	146
Total	142	15	6,257

Source: NAI, Kwale Dist. 1/141, Volume VI: Annual Report, Aboh Division, 1938, p.57.

Table XVI

Tours of Towns and Villages for Vaccinations Against Smallpox, Aboh Division, 1939

Town/Villages	No. of Cases	No. of Deaths	No. of Vaccinations
Ndoni	5	3	524
Ise Iwene	3	-	78
Onuogbokor	12	1	887
Abbi	11	-	468
Ossissa	8	2	569
Ogume	6	-	507
Iselegu	1	1	230
Utagbauno	2	1	584
Total	48	8	3,844

Source: NAI, Kwale Dist 1/141, Volume VII: Annual Report, Aboh Division, 1939, p.41.

These tables show that intensified campaigns reduced the number of cases and the number of deaths from smallpox as the years progressed, a trend that continued in subsequent years. Only one outbreak of smallpox occured in 1941 and 1942 respectively.[34] No cases were reported in the province in 1943 and 1944, but 7,672 and 14,733 persons respectively were inoculated.[35]

The success achieved within this period resulted from increased employment of vaccinators. All Native Administrations recruited sanitary inspectors or overseers and the provincial government posted a vaccinator, P. Aghagbon, to Obetim Kwale to help cover the division through tours and campaigns.[36] These junior officers undertook enlightenment campaigns to allay the fears of the villagers. Their common cultural background meant that the villagers more readily accepted their views. Typically, each campaign stressed the necessity of sanitation, the value of public health measures and reporting outbreaks of diseases to the health authorities.

More successful vaccinations recorded within this period also attracted more people to the vaccination exercise. Successful vaccinations increased from fifty percent in the earlier period to over seventy percent due to the improved

34. NAI, Kwale Dist 1/144 Vol. IX: Annual Report, Aboh Division, 1941, p.81; Vol. X: Annual Report, Aboh Division, 1942, p.132.

35. Annual Report, Warri Province, 1935, p.17; NAI, Kwale Dist 1/141 Vol. IV: Annual Report, Aboh Division, 1936, p.27.

36. Annual Report, Warri Province, 1935, p.17; NAI, Kwale Dist 1/141 Vol. IV: Annual Report, Aboh Division, 1936, p.27.

potency of lymph as recommended by the Deputy Director of Sanitary Services, Dr. Matthew Cameroon Blair, in 1921.[37] This development convinced sceptics of the effectiveness of disease control.

Lastly, laws instituting harsh punishment against people who deliberately concealed cases of smallpox or resisted vaccination compelled the villagers to surrender themselves for treatment and vaccination. Chiefs and the educated elite no longer hesitated to report cases to the health authorities. In 1945, J.O. Okoro of Okpolo clan reported an outbreak of smallpox in Enwe town, while Ezerogha of Oghese village in Emevor reported a concealed case in his town the same year.[38]

(B) Malaria

The control of malaria occupied the attention of the provincial authorities. We have already discussed the extension of mosquito control measures to the Labour Health Areas. Similar measures were extended to some rural areas. After the death of Rev. Father Cahil from yellow fever in 1942, a renewed sense of urgency permeated the anti-mosquito campaign undertaken in the Abraka-Orogun area. A sanitary inspector remained there for several weeks after which the medical officer, Dr. John Tower Sorley, recommended a follow up exercise which the Kwale NA continued.[39]

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37. Annual Report, Nigeria, 1921, p.72.

38. Vaccination Ordinance No. 11 of 1873 in *Laws of Colony of Lagos* Vol. 1 (London: Stevens and Sons 1902), p.3; NAI, Ughel Dist 1/224, p.329: DO Urhobo Division to Vaccinator 10.9.45.

39. Annual Report, Aboh Division, 1942, p.132.

The NA dispensaries and maternity homes as well as the government dispensaries received drugs for the cure of malaria. Quinine still featured prominently in the treatment provided by the government and missionary health institutions.[40] Dr. A.C. Paterson, however initiated experiment in the use of the new drugs, Atebrin and Plasmochin Simplex. He performed an experiment on six Europeans whom he gave 0.1 gram of Atebrin three times daily in conjunction with 0.01 gram of Plasmochin Simplex three times daily for four days. Though he admitted that the six cases did not provide enough evidence to make valid statements, he concluded that Atebrin was not so effective as quinine in the treatment of malaria because of side effects such as serious stomach ache. It could only be used on patients allergic to quinine. Thus new drugs came into use as a supplement to quinine.[41]

Malaria, unlike other endemic diseases, could also be effectively treated through the use of local herbal concoctions. Often family members continued indigenous treatment at home without consulting even traditional healers or going for modern treatment. We have already described the treatment in Chapter One (see note 18). Many people believed that this traditional treatment was more effective than modern medicine.[42] Nevertheless, malaria did constitute one of the

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40. NAI, Ughel Dist 1/1550p.28: NA Treasurer Ughelli to ADO Urhobo 23.3.51.

41. A.C. .Paterson, "Report on the treatment of malaria by Atebrin and Plasmochin Simplex" *West African Medical Journal* Vol. VI, No. 1V, 1932, pp.68-70.

42. J.O. Chikogu, "Patterns of Utilisation of Health care services in rural communities: A case study of Amai Town" Department of Physical and Health Education, University of Ibadan, M.ED, 1984, p.58.

major diseases treated in most dispensaries. In Aboh Division cases of malaria ranked next to ulcers, scabies and constipation among the diseases treated in the dispensaries.[43] In 1944 alone, 2,001 persons received treatment for malaria in the Ijo Division.[44]

(C) Yaws

Yaws, another tropical contagious disease endemic in Africa, was prevalent in the province. Though not a killer, it disabled the sufferers with its ulcers, crippling contractures, facial destruction and palm and plantar lesion.[45] Out of 681 persons examined at Orogbo near Warri during the 1931 medical census only ninety-three children under six years had no yaws at all. Fifty-one, aged between two and twelve had florid yaws while the rest of 537 persons, aged three years and above, had a history of yaws. Only children less than a year old did not suffer yaws.[46]

In 1933, Dr. F.W. Purcell studied the aetiology of yaws in West Africa and established that it was a disease of infancy and childhood caused by lack of hygiene or contact with an affected person. Good hygiene, personal cleanliness, and a

43. NAI, Kwale Dist 2 KNA 99pp. 156-305: Returns by Dispensers to DO Aboh Division Jan-Dec. 1938.

44. NAI, War Prof 1, WP 235: Annual Report, Warri Province 1944, Enclosure p.48, p.3.

45. C.J. Hacket, "Yaws" in *Health in Tropical Africa During the Colonial Period* eds E. Sabben-Clare, D.J. Bradley and Kirkwood (Oxford: Clarendon Press, 1980), p.84.

46. Turner, *Census of Nigeria 1931 Vol. VI*, p.21.

clean environment constituted the best measures for preventing yaws. A series of lecture campaigns in courts, divisional and clan councils and schools by medical officers, dispensary attendants, sanitary inspectors and overseers emphasised preventive measures against yaws and other diseases. These were re-enforced by a public health component being added to the hygiene syllabus for schools. Dr. C.J. Hackett also contended that the successful elimination of yaws reflected improved economic and social conditions as much as it did the use of drugs.[47]

Bismuth injections proved very effective for the treatment of yaws. District medical officers toured schools, dispensaries and other public places to treat yaws and some other ailments.[48] They had monthly itineraries on places to visit. In August, 1941, the medical officer, Forcados, Adeniga Olabode Coker, had the itinerary shown on Table XVII below to guide his tours.

47. F.W. Purcell, "Aetiology of Yaws" *West African Medical Journal*, VII (2), 1933, p.96; Hacket, pp.83-85.

48. NAI, War prof 1, WP 437 pp.16-19: Resident WP to SMO Enugu 23-12-41.

Table XVII

Itinerary-Medical Officer Forcados August 1941

Date	Place Left	Time	Place Arrived	Time
5-8-41	Forcados	11.00 a.m.	Aghoro	1.30 p.m.
"	Aghoro D.	12.10 p.m.	Ojobo	5.30 p.m.
"	Ojobo, S.	6.20 p.m.	Torugbene	7.15 p.m.
6-8-41	Torugbene	7.55 a.m.	Keremor	8.30 a.m.
"	Keremor	9.30 a.m.	Sampor	10.45 a.m.
"	Sampor	11.10 a.m.	Aleibiri	12.10 p.m.
"	Aleibiri D&S	12.20 p.m.	Tuomor	12.35 p.m.
"	Tuomor	1.20 p.m.	Ayamasa	1.55 p.m.
"	Ayamasa	2.20 p.m.	Patani	7.50 p.m.
7-8-41	Patani, D.	10.20 a.m.	Sagbama	10.50 a.m.
"	Sagbama, D.	11.40 a.m.	Ogoloma	11.50 a.m.
"	Ogoloma	12.05 p.m.	Angiama	12.45 p.m.
"	Angiama	1.05 p.m.	Bedebri	1.25 p.m.
"	Bedebri	2.05 p.m.	Angalabri	2.15 p.m.
"	Angalabri	2.50 p.m.	Bomadi	3.45 p.m.
"	Bomadi	4.05 p.m.	Oboro	4.30 p.m.
"	Oboro	4.50 p.m.	Okpokunu	5.10 p.m.
"	Okpokunu	5.30 p.m.	Akugbene	7.30 p.m.
8-8-41	Akugbene, D&S	8.20 a.m.	Ogodobri	8.55 a.m.
"	Ogodobri	9.10 a.m.	Ezebri	9.30 a.m.
"	Ezebri	10.05 a.m.	Ogbodobri	10.50 a.m.
"	Ogbodobri	12.15 p.m.	Okrika	1.00 p.m.
"	Okrika, S.	1.45 p.m.	Yakoroma	2.20 p.m.
"	Yakoroma	3.20 p.m.	Gbekebor	3.50 p.m.
"	Gbekebor	4.10 p.m.	Forcados	6.30 p.m.

Note: D = Dispensary
S = School

Source: NAI, War prof 1, WP 437: Private Practice by Medical Officers, p.11.

To satisfy the demand for Bismuth injection for the treatment of yaws, the medical officers did not restrict their tours only to places listed in their itinerary. They also engaged in private practice at other places. This practice which started in the Eastern Provinces in about 1925 spread to other provinces later.[49] In 1941, the activities of Dr. Coker in Ijo division was described as follows:

> The launch approaches a village and blows its whistle. The Medical Officer goes ashore with a black bag; he calls for people who want injections, does the injection, sweeps the takings into the black bag, goes to the Launch and pushes to the next village.[50]

The Ijo division experienced the highest infestation of yaws in the province. To combat the scourge of yaws in the division the Medical Department in collaboration with the provincial authorities gave a special privilege to dispensary attendants in that division by licensing them to administer injections for the treatment of yaws, leprosy and dysentery to reinforce the activities of the medical officers.[51]

The Medical Department adopted the use of a new drug, Acetylarsan, as an alternative or substitute for Bismuth injection following an experiment carried out by Dr. C. Wilson in 1937. Wilson's research proved that acetylarsan was not only as effective as Bismuth but also had no danger of over-dose. It was also cheaper.[52] The Bismuth treatment coupled with Acetylarsan, enhanced the

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49. Hacket, in *Health in Tropical Africa*, p.85.

50. NAI, War prof 1, WP 437 p.8: DO Forcados to Resident Warri 9-9-41.

51. NAI, War prof 1, WP 437 pp.16-17: Resident WP to SMO Enugu 13-12-41.

successful eradication of yaws in the province as in other parts of the country. The effectiveness of these drugs popularized modern medicine among the Delta peoples. In 1932, the Resident, J.W.C. Rutherfoord, admitted that the illnesses for which the people sought modern medical attention included yaws because it was quickly cured.[53] His immediate successor in office Mr. Edward Albert Miller confirmed, a year after, that medical attention to yaws had become extremely popular owing to the "susceptibility of the complaint to treatment".[54]

(D) Leprosy

John Illife has rightly identified leprosy as a common disease in tropical Africa. The peoples of Warri Province suffered it as much as the other areas he studied. Society usually ostracized sufferers, forcing them into permanent isolation in uninhabited areas, where they were forced to fend for themselves. Some societies even denied them burial rites.[55] In Warri Province, most lepers lived in the bush and therefore escaped the early attention of the colonial authorities. Only a few cases attended the Warri Hospital: sixty-three in 1930 and forty-one in

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52. C. Wilson, "The treatment of yaws with Acetylarsan" *West African Medical Journal* IX (2) 1937, p.28.

53. Annual Report, Warri Province, 1932, p.64.

54. Annual Report, Warri Province, 1938, p.33.

55. T.C.G. M. Mayer, "The Distribution of Leprosy in Nigeria with special reference to the Aetiological Factors on which it Depends (Part I) *West African Medical Journal* IV (1) 1930, pp.12-14; John Iliffe, *The African Poor: A History* (Cambridge: Cambridge University Press, 1987), p.215.

1931.[56] In 1932, Dr. Jones, the medical officer of health, revealed the true situation of the incidence of leprosy through a leper census he conducted in five village groups in the Kwale division. Thirteen percent of the people he examined suffered from the disease.[57]

The high incidence of leprosy in the neighbouring Benin Province had, however, been detected earlier. By 1922, seven camps with 588 lepers had been founded in Asaba division alone.[58] Though they had neither been well organised, nor had there been any treatment for them. They were segregated from the healthy population but provided with little medical attention. In 1928, the Medical Department converted the Education Office at Asaba into a dispensary, appointed a dispenser and supplied equipment for the care of the lepers there and erected a new building at Ibusa for treating those in the Ibusa camp.[59] The RCM offered to assume the supervision of leprosy work in the province. When Dr. T.C. Mayer, the local medical Secretary of the British Empire Leprosy Relief Association, visited Asaba a year after his appointment in 1927 he recommended the adoption of a central settlement in preference to the existing system of settlements.[60]

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56. Turner, *Census of Nigeria 1931*, Vol. VI, p.33.

57. Annual Reports, Warri Province, 1932, p.63, 1933, p.33.

58. NAI, CSO 26/2/09131: Annual Report, Benin Province, 1922, p.25.

59. NAI, CSO 26/2/14617 Vol. IV: Annual Report, Benin Province, 1928, pp.19-25.

60. Ibid, p.94.

This recommendation resulted in the selection of a site on the Ossiomo River about thirty-three miles from Benin on the Agbor road for a large leper settlement. The Medical Department earmarked the centre to control leprosy in the Benin and Warri Provinces. By 1930, the Catholic Bishop, Broderick, had initiated moves to recruit a Catholic medical officer from Europe.[61] Work at the Ossiomo site started in 1931 and by the end of 1932 temporary quarters for eighty lepers and semi-permanent quarters for fourteen lepers, a hospital for eighteen, a dispensary, store and a water tank had been built and all necessary equipment and furnishing provided with a total grant of six thousand pounds (£6,000) from the Colonial Development Fund.[62]

The NAs in Benin and Warri Provinces contributed to all recurrent expenditure, including paying staff salaries by remitting their annual quotas to the settlement. The NAs also sponsored patients admitted at Ossiomo by paying for their feeding. In 1934, for example, they paid six pounds for each leper they sponsored.[63] Patients, not sponsored by any NAs paid the same amount per annum while they all received drugs free.[64]

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61. NAI, RCM BD Vol. II 6/1 pp.7-8: Guild of St. Luke, Cosmass & Damian to Vicar RCM Asaba 29-12-30.

62. NAI, CSO 26/2/14617 Vol. VIII: Annual Report, Benin Province, 1932, p.34.

63. NAI, CSO 26/2/14617 Vol. X: Annual Report, Benin Province, 1934, p.5.

64. NAI, Ijaw (W) 4, WI 430 Vol. II p.253: Memo Resident WP to DOs 30-4-34

In September 1933, Mr. William Davies, a sanitary suprintendent, opened the settlement with ninety-six patients, because the RCM had failed to recruit a medical doctor before that date.[65] Doctor Arthur Howard took charge between August and November 1934, when the doctor recruited by the RCM, Dr. Louba Langauer, assumed duty as the medical superintendent of the settlement. She came with two other female assistants.[66]

Dr. Langauer consolidated the work at Ossiomo before the Nigerian Leprosy Service took direct control of the centre in 1945 mainly because leprosy control work had been well established there. She supervised the building of many new facilities like permanent quarters, a court house, latrines, bathrooms, kitchen and school for out-patients.[67] The centre also started producing Hydnocarpus oil, the main drug for the treatment of leprosy at the time.[68]

In order to provide for lepers who could not attend Ossiomo or the out-patient clinics at Warri and Sapele hospitals Dr. Langauer opened an out-patient clinic at Umutu in 1942 for the treatment of non-infectious lepers. She visited the clinic monthly from Ossiomo during which time she diagnosed new cases and supplied drugs.[69] With these institutions and facilities a reasonable foundation had

65. NAI, CSO 26/2/14617 Vol. IX: Annual Report, Benin Province, 1933, p.186.

66. Annual Report, Benin Province, 1934, p.6.

67. NAI, CSO 26/2/14617 Vol. XIV: Annual Report, Benin Province, 1940/41, Enclosure p.311, p.8.

68. *Ibid.*, p.11.

69. Annual Report, Aboh Division, 1942, p.129.

been laid for the control of leprosy in the two provinces.

The control measures instituted for leprosy impressed the Delta peoples because of their effectiveness. Though hydnocarpus oil injection could not cure leprosy as fast as the Bismuth injection cured yaws, it raised much hope in the lepers who might otherwise have despaired of recovery since there was no effective traditional cure for leprosy. Between 1937 and 1941, thirty-four patients were discharged from Ossiomo, certified cured. This meant that they could be re-integrated into the larger society.

No doubt this encouraged more lepers to seek admission to Ossiomo. By 1941, the number of in-patients at Ossiomo had risen from ninety-six in 1933 to 447.[70] Throughout the period the NAs had their quotas filled up while the out-patients clinic at Umutu treated more patients than most other clinics in Benin Province.[71]

Segregation of lepers in camps did not only prevent the spread of the disease but also provided lepers with a healthier environment in which to live. Instead of roaming in uninhabited areas, they now found themselves in a place with modern facilities such as piped water, electricity, school, church and medical care. Therefore, most of them were not eager to return home even after their discharge. They preferred to stay put in the camps and fend for themselves. They believed that the stigma still remained, especially if they had suffered loss of toes and

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70. Annual Report, Benin Province, 1940/41, Enclosure p.311, p.11.

71. Annual Report, Aboh Division, 1943, pp.167 and 169; NAI, War Prof 1 WP 349, p.51: Medical Statistics Leper Camps 1946-1947.

fingers. All the ex-patients (still living on the camps) interviewed at the Eku camp recently expressed happiness to continue living in the camp. According to Johnson Ogbe:

> I feel better and happier here than at home. When you see healthier people and those you were ahead of progressing you feel very bad. The stigma makes it unpleasant to go back to your community. Here we are the same and nobody mocks at the other.[72]

Madam Agnes Onwugbolu who was admitted at Ossiomo during the Second World War narrated how people avoided her when they knew that she had the disease. Children despised her and she was not allowed to visit anybody in the community. She doubted that the attitude would change especially as the disease had disfigured her badly.[73] Editorial comments of newspapers and public opinion calling upon the hospital authorities in the Warri Province to ban lepers from receiving treatment in conventional hospitals appear to justify the fears of the ex-lepers. The Southern Nigeria Defender in one of its editorials on the issue advised the provincial authorities that "to admit lepers into any social institution existing here is simply deplorable." Mr. Joseph Okitikpi's "soul rebelled" on hearing that "lepers were permitted to beseige the Sapele African hospital rubbing shoulders with other out-patients". They all called upon the hospital authorities to stop the

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72. Interview, Johnson Ogbe, Aged 45, Discharged Leper in Camp, Tapping Rubber and Farming, Eku Settlement, 29 April, 1995.

73. Interview, Agnes Onwugbolu, Aged 70, Discharged Leper in Camp. Employed by the State Leprosy Service, Eku Settlement, 29 April, 1995.

practice.[74] Thus the mutual rejection between the lepers and their communities further fostered the popularity of leprosy control measures.

(C) Native Administration Medical and Health Activities

(a) Dispensaries: The medical and health activities of the NAs concentrated in the rural areas to complement the medical work of the provincial and central authorities. As planned, the colonial state launched the programme of NA Dispensaries in 1930, but Warri Province delayed erecting the buildings and training staff at Sapele Hospital.[75] By April 1931, four dispensaries opened, one each in Ughara, Orerokpe and Okpara in the Sapele District and Abbi in the Kwale District.[76] Between 1932 and 1944, thirteen more dispensaries were set up at Utagba Uno, Aboh, Abraka and Ashaka in the Aboh division; Ramos River, Aleibiri, Akugbene, Ogoibiri, Patani and Sagbama in Western Ijo division; Ughelli and Owe in the Sobo division and the Benin River in the Sobo-Jekri Division.[77]

These institutions initially satisfied the aspirations of the educated elite who now lived in the rural areas in greater numbers where they worked as teachers, NA officials and Church workers. They demanded more modern medical facilities and

74. Editorial Comments "Health Authorities". *Southern Nigeria Defender*, 26 January 1944, p.2; 3 February 1944, p.3; 7 February 1944, pp.2 and 3.

75. Annual Report, Warri Province, 1930, p.292.

76. Annual Report, Warri Province, 1931, p.38.

77. NAI, War Prof 1, WP 235: Annual Report, Warri Province, 1944, p.15; NAI, War Prof. 1, WP 235 Vol. III: Annual Report, Warri Province, 1946, pp.60-62.

encouraged their relatives to benefit from them. Dispensaries enjoyed almost instant popularity wherever they were opened. When the Orerokpe and Ughara dispensaries opened in April 1931, they attended to 9,106 patients in nine months.[78] Those in other divisions also attended to reasonable number of patients initially as Table XVIII below shows. In fact, the new facilities could hardly meet the needs of the high number of patients coming for treatment.

In 1936, however, they experienced a dramatic fall of over fifty percent of previous year's attendances. The monthly attendances in these dispensaries in 1936 shown in Table XIX clearly shows the downward trend. The attendance at Aboh

Table XVIII
Attendances in Abbi, Utagbauno and Aboh
Dispensaries in Aboh Division 1933 - 1941

Year	Abbi	Utagbauno	Aboh
1933	3168	1635 (June-Dec.)	Not yet opened
1934	4007	3841	1117 (May to Dec.)
1935	5207	4974	2625
1936	3949	2811	1116
1937	1656	947	727
1938	1070	917	602
1939	1818	723	n.a
1940	2400	719	n.a
1941	2211	855	n.a

Note: na = not available.

Sources: NAI, Kwale Dist.2, KNA 99: NA Dispensaries Returns, pp.1-2, 31-539; Kwale Dist. 2, KNA 99 volume II: NA Dispensaries Returns, pp. 312-437; Kwale Dist. 5 ANA 31: Aboh Native Administration Dispensaries Returns, pp.4, 33, 70, 115-266

78. Annual Report, Warri Province, 1931, p.38.

and Utagbauno dispensaries in June 1936, fell below thirty percent while that of Abbi, in the same month, fell below thirty-three and one-third per cent of those of May.

Table XIX

Monthly Attendances in Abbi, Utagbauno and Aboh Dispensaries - Aboh Division 1936

Month	Abbi	Utagbauno	Aboh
January	497	446	287
February	800	521	249
March	548	543	161
April	424	441	141
May	352	325	189
June	118	47	51
July	206	75	68
August	203	53	38
September	230	109	81
October	231	81	164
November	236	80	114
December	104	90	73
Total	3949	2811	1616

Sources: NAI, Kwale Dist. 5: ANA 31: Aboh NA Dispensaries Returns 1934 - 38,pp. 70 - 144; Kwale Dist.2, KNA 99: Kwale NA Dispensaries Returns, pp. 84-153.

The major reason for the fall of dispensary attendance did not stem from a sudden reversal in acceptance, but from economic considerations. In June 1936, the provincial authorities introduced a fee of one penny for "every dose of medicine" and three pence for "every wound or other diseases treated to a conclusion."[79] Government and NA workers and school children were exempted,

79. NAI, Kwale Dist. 2 KNA 3 Vol. II, p.209: Resident WP to DOs 30-4-36.

but everyone else had to pay.

Consumers of medical treatment in dispensaries had to look for other treatment options, the most important of which included treatment in hospitals or from traditional healers. Earlier, the Resident, J.W.C. Rutherfoord, had noted that some patients preferred more skilled treatment in a distant hospital to attending a neighbouring dispensary.[80] This suggests that some rural Delta people had become aware of the quality of treatment given by dispensers and doctors and opted to spend more to consult a doctor. Only comparatively well-off people could afford this option. Unable to pay dispensary fees, the rural people favoured traditional healers who charged little or no fees because their clients were related to them. Gifts in kind often provided enough compensation for their services.[81] Apart from fees, the services of traditional healers remained indispensable to some patients. Rutherfoord observed in 1932 that "hopeless cases prefer(red) native treatment". His successor in office; Miller, noted the following year, that "The Native doctors still enjoy(ed) large practices and the majority of the people consult(ed) them."[82] These official reports confirm the views of most Delta peoples that they sought modern medical treatment for ailments it could cure effectively and continued with traditional treatment for diseases it (modern medicine) could not control. Infact, Steven Feierman has shown that medical pluralism also prevails in other parts of Africa already studied since the

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80. Annual Report, Warri Province, 1932, p.64.

81. Interview, John Denedo, Aged 52, Librarian, Abraka, 9 February, 1993.

82. Annual Reports, Warri Province, 1932, p.64; 1933, p.33.

introduction of modern medicine.[83] Dispensary fees in the Warri Province helped this phenomenon which started earlier to manifest.

Dispensary fees did not, however, detract from the popularity of dispensaries in the Ijo Division as in other divisions. In 1943, they recorded a twenty-five percent increase in attendance and maintained this in subsequent years.[84] A comparison of revenue collected in six NA dispensaries in Ijo division and five NA dispensaries in Aboh division between 1939 and 1944 shown in Table XX below brings out the differential attitude to dispensary treatment in the two divisions more clearly.

Table XX

Revenue collected in six N.A. Dispensaries in Ijo Division and Five in Aboh Division 1939-1944

Year	Ijo Division	Aboh Division
1939	n.a.	£20: 2: 7
1940	n.a.	8:12: 8
1941	n.a.	16: 3: 6
1942	£68:17: 8	36: 9:11
1943	£108: 3: 7	36:14: 8
1944	£146: 1:11	46:12:10

Note: n.a. = Not available

Source: NAI, War prof 1, W.P. 235: Annual Report Warri Province 1944, Enclosure p.48; p.6; NAI, Kwale Dist 1/141 Vol. IX: Annual Report, Aboh Division 1941, pp.73 and 77; NAI, Kwale Dist. 1/41 Vo. X: Annual Report, Aboh Division 1942, pp.29 and 31; Vol. XI: Annual Report, Aboh Division, 1943, pp.167 and 169; Vol. XII: Annual Report, Aboh Division, 1944, pp.167 and 217.

83. Feierman, "Struggles for Control", pp.74-80.

84. Annual Reports, Warri Province, 1938, p.15; 1939, p.4; 1941 Onwards, (1942), p.15; (1943), p.12, (1944), p.6.

In 1944, the Resident, Robert Leonard Bowen, rightly attributed poor revenue acruing to dispensaries in other divisions to poor attendance by adult indigenes. According to him they catered for little more than school children and officials.[85] That situation remained for long after the period covered by this chapter and exemplified the general attitude of the people to dispensary services after the introduction of fees. Infact, the continued popularity of dispensaries in Ijo Division resulted from situation and conditions peculiar to that division.

First, the provincial authorities, with the permission of the Medical Department, granted licences to dispensary attendants in Ijo division to administer injections for yaws, dysentery and leprosy to augment the work of the medical officers to whom most areas in the division were not accessible.[86] Incidentally, most Delta peoples preferred injections to tablets, given in their place to patients in other divisions, because of reasons already advanced in chapter one.[87] (see paragraph below note 44). So, while patients in Ijo Division were prepared to pay for injections, patients in other divisions complained that the medicines prescribed for them were "not strong enough".[88] Unless they waited for the monthly visits of the medical officers, which were never regular, they did not get the injections they

85. NAI, War Prof. 1, WP 235. Annual Report, Warri Province 1944, Enclosure p.49, p.73.

86. Annual Report, Warri Province, 1941 Onwards (1946), p.9, NsAI, War Prof 1, WP 437, p.16: Resident WP to SMO Enugu 23-12-41.

87. Annual Report, Warri Province, 1933, p.33.

88. NAI, Kwale Dist. 1/141 Vol. VI: Annual Report, Aboh Division, 1938, p.146.

cherished. Thus, they declined attending dispensaries to receive the other "unsatisfactory" modes of treatment given to them.

Besides the peoples perception of medicines introduced into the blood stream, injections acquired popularity from their effectiveness in curing yaws and other diseases. In addition some people equated their body reaction to injections in those days to the effectiveness of the treatment.[89] The view of David T. Okpako on popular perception of the body's reaction to drugs is very apt in understanding the Delta people's opinion about the efficacy of injections:

> Since people are brought up to believe that remedies used to treat diseases can only do good, violent toxic reactions to drugs such as diarrhoea and vomiting or general malaise are some times viewed positively as signs that the medicine is working especialy if the patient gets over the illness.[90]

Another situation peculiar to the Ijo division consists of its riverine environment. We have pointed out in chapter one (see note 30) that it limited the scope of traditional medicine because of comparative lack of vegetation. The implication was that the option of consulting herbalists was not open to people in Ijo division as much as to people in other divisions. Similarly, the option of attending a hospital was also deterred by the inaccessibility of the hospital town, situated at the Western extreme of the division, because of inadequate water

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89. Interview, Daniel Adam Obagbinoko, Aged 80, Retired Company Dispenser and Patent Medicine Dealer, Oviorie Ovu, 25 April, 1995.

90. David T. Okpako, "The Impact of Traditional African Medicine on the use of Modern Drugs". *Ethnic Difference in Reaction to Drugs and Xenobiotics* Eds. Werner Kelow, H., Werner Goedde and Dharam P. Agarwal (New York: Alan Lissinc, 1986), p.70.

transport.[91] Thus, the enhanced dispensary services remained the only feasible option for them.

Another factor accounting for the unpopularity of dispensaries in general was poor interpersonal relationship between dispensary attendants and patients. Some inefficient attendants some times treated patients with hostility and rudeness. In 1942, the district officer kwale, Ian Robert Penincuick Heslop, attributed improved dispensary attendance to the work of "Dispensary Attendants of higher quality", recruited that year. He noted that the new "men were above the standard of their predecessors."[92] The two dispensaries in Aboh NA also recorded a good average attendance because of the recruitment of a new attendant that was trained by the CMS and who toured the villages for vaccinations. Consequently, in 1942-43 the dispensaries in Aboh division generated greater revenues than between 1939 and 1941 as shown in table XXI below.

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91. Ubrurhe, "Urhobo Traditional Medicine" p.162; Ijaw (W) 14 (No File No.): Annual Report, Western Ijaw Division, 1948, p.8.

92. Annual Report, Aboh Division, 1942, p.29.

Table XXI
Revenue Collected in Aboh and Kwale Native Administration Dispensaries
1939-1944

Year	Kwale N.A.	Aboh N.A.
1939	£11: 7: 5	£ 8:15: 2
1940	£13: 7: 3	£ 8: 5: 5
1941	£12.12. 7	£ 3:10:11
1942	£25: 2:11	£ 9: 7: 0
1943	£26: 0:11	£10:13: 9
1944	£25:12: 8	£16: 0 2

Sources: NAI, Kwale Dist 1/141 volume IX: Annual Report, Aboh Division, 1941, pp.73 and 77; volume X: Annual Report, Aboh Division, 1942, pp.29 and 31; volume XI: Annual Report, Aboh Division, 1943, pp. 167 and 169; volume XII: Annual Report, Aboh Division, 1944 pp.167 and 217.

The revenues collected in 1942 amounted to an increase of over 100 percent in the Kwale area and 200 per cent in the Aboh area, over those of the previous year. Scholars have noted the conjunction between high performance by hospital staff or dispensary staff and the popularity of modern medical institutions in other areas. In his study of the Idoma, Robert G. Armstrong discovered that most people disliked seeking modern treatment because staff shouted at them and did not give them respect.[93] Among the Yoruba Ulli Beler concluded that patients patronised "quack doctors" because the:

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93. R.G. Armstrong, "Idoma Traditional Attitude Towards Disease". The *Traditional Background to Medical Practice in Nigeria. Institute of African Studies, University of Ibadan, Occasional Publications No. 25* (Ibadan: Ibadan University Press, 1971), p.4.

Yoruba man or woman wanted to be given time by his doctor and he got it more from the quack doctors than from hospital staff.[94]

(2) NA Maternal and Childwelfare Programme

Maternal care and child welfare programmes received very little attention from the NAs during this period. Not until December 1944 did the Sobo (Urhobo) NA open a maternity home at Ughelli.[95] This was several months after the editor of Southern Nigeria Defender decried the inadequate maternal services in the province and called upon the NAs to establish maternity homes without delay or assist the CMS in their maternity work at Igbudu and other centres.[96] Communities and individuals had earlier pressured the government for the establishment of maternity homes. For example, the major request the Patani community presented to Governor Richard and Lady Richards during their visit to Patani on September 20, 1944, was "a well equipped maternity home".[97] Even the African hospitals had not given adequate attention to maternity work. Except for the Warri African hospital which recorded births in 1943, other African hosptials offered only ante-natal services.[98] Only the CMS had well-established maternal health care facilities in the province within this period. Though we are yet to

94. U. Beler, "Quack Doctors in Yoruba Village" Dokita I (1), 1960, p.58.

95. NAI, War Prof 1, WP 206/1, p.2: DO Urhobo Div, to Resident WP 20-3-45.

96. Editorial Comment, *Southern Nigeria Defender*, 7 March, 1944, p.2.

97. Patani Community, "Welcome Address" *Southern Nigeria Defender*, 21 September 1944, p.1.

98. Annual Report, Warri Province, 1944, Enclosure p.48, p.4 and p.68.

discuss the medical activities of the CMS, our discussion here on the attitudes of Delta women to maternity services will incude their reaction to CMS maternity homes. When the CMS maternity home opened at Bethel in 1930, it recorded 446 ante-natal cases and 103 births.[99] The following year the number had risen to 602 ante-natal cases and 165 births.[100] Similarly, in Warri hospital there was marked increase in ante-natal attendance and deliveries. Ante-natal cases rose from 393 in 1943 to 422 in 1944 while deliveries rose from 96 to 135.[101]

Initially, rural and urban women in the province disliked modern treatment during pregnancy and more especially during delivery, because of deep-rooted cultural beliefs. Faithful house wives were believed to give easy birth to their babies without problems while faithless ones had to confess their sins or face the prospect of a difficult birth to their babies.[102] Samuel Erivwo discussed the value of female chastity:

> Faithfulness and chastity, the necessary ingredients of a woman's virtue, are highly prized in her, more so than beauty. A woman who lacks these qualities is regarded as a disgrace to her husband and parents. Should a wife of a member of the family have coition with either a man from the same family or from another, the ancestors of the woman's husband, it is believed, would intervene and afflict the woman with a sudden illness until she confesses to the family elders, before the ancestral shrine. If, however, she was not arrested by the police of erivwin, (the abode of departed, and

99. Annual Report, Warri Province, 1930, p.317.

100. Annual Report, Warri Province, 1936/37, p.68.

101. Annual Report, Warri Province, 1944, p.38.

102. Interview, Lucy Onodovwerho, Aged 75, Petty Trader, Abraka, 2 May, 1995.

> also the departed themselves) she was sure to confess on the day of her travail or have endless labour and be incapable of bringing forth her child. As soon as she had fully confessed her sins, she would be safely delivered of her child.[103]

Erivwo regarded maternity homes and hospitals as potential hazards to morality. According to his view maternity hospitals:

> Lower the sex morality of the women fold... some women are now said to care very little whether or not they are chaste, since once in a maternity home they would be safely delivered without the necessary humiliation of confession.[104]

Such strong accusation concomitant with hostility towards certain modern methods like Caesarean section and episiotomy actively discouraged most mothers from attending maternity homes for child birth.[105] Educated Christian women challenged these attitudes and pioneered initiatives in making new methods acceptable.

Meanwhile many mothers preferred the assistance of traditional midwives for serveral reasons. Some considered them more proficient in child delivery because of the effective herbs they employed and their kindness to mothers in labour. Conversely, they complained of bullying by nurses and midwives.[106]

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103. Erivwo, *Traditional Religion and Christianity in Nigeria*, p.61.

104. Erivwo, *History of Christianity*, p.118.

105. Interview, Lucy Onodvwerho.

106. Interview, Ogbokor Aruerue, Aged 68, Traditional Midwife, Iyerughe, 15 December, 1991.

Some other mothers who sought ante-natal treatment could not afford hospital and dispensary fees as well as procure baby materials required from them before hand. Such mothers protested high fees after the NAs instituted maternity work.[107] The traditional attendants charged little or no fees because of close relationship with their clients.

(3) Native Administrations and Sanitation

Besides establishing dispensaries and maternity homes the NAs initiated a programme designed to prevent diseases in the rural communities through instituting sanitation measures. Rural sanitation policy stressed popularising already established measures at the local level. They employed labourers who assisted the dispensary attendants in keeping the dispensary premises and public places such as markets and courts clean,[108] as directed by the Director of Medical and Health Services, Dr. Walter Burford Johnson in 1932. He emphasised the importance of dispensaries in serving as a model to teach the populace to associate health and well-being with cleanliness through the following measures:

(1) The building must be good, kept in repair and thoroughly clean.

(2) Ample good water must be available in the dispensary.

(3) This water must be boiled before being given to patients along with their medicines. Therefore a kitchen of sorts is necessary.

(4) The water must be reasonably clean.

(5) Dirty dressing must be properly disposed of, an incinerator should be in action.

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107. NAI, Kwale Dist 1/813: Ashaka Maternity Centre, pp.44-57.

108. NAI, Kwale Dist 1/74/2: Annual Report, Aboh Division, 1934, p.38.

(6) The Dispensary Attendants must be, and look thoroughly clean and tidy.

(7) Everything about the dispensary must be obviously and excessively clean, no dust, no cobwebs, all glasses (and) enamel iron ware washed and polished.[109]

In order to put these goals into practice, he directed the NAs that their labourers and sanitary inspectors should live near the dispensaries and other public places in order to influence the villagers who visited the dispensaries and other public places.[110] Aboh NA for instance, stationed its labourers at Ogume, Aboh and Ashaka stations as well as at Ashaka, Obiaruku and Amai markets.[111] These public places where the villagers gathered frequently served as demonstration centres for modern methods of disposing refuse and nightsoil and keeping compounds clean. Many villagers adopted the sanitation methods in their life.[112]

NA sanitary inspectors and overseers supervised these labourers in executing their sanitary duties. They administered vaccinations in the government stations and toured the surrounding communities for inspection of houses and vaccinations. For instance, in 1938, the Urhobo division appointed a sanitary inspector, S.I. Overare to take charge of all sanitary matters. He wisely linked NA sanitation rules with indigenous measures securing the co-operation of the

109. NAI, Kwale Dist. 2, KNA 3 Vol. II: Annual Report, Aboh Division, NA Dispensaries, 1932, p.103.

110. Ibid., p.106.

111. Annual Report, Aboh Division, 1934, p.39.

112. Annual Report, Aboh Division, NA Dispensaries, 1932, p.103.

Emeha and *Ovrawa* age grades responsible for sanitation in the villages. In 1939, the district officer, Captain John Charles Forbes Pender commended this salutary initiative noting the friendly interaction between Overare and the people who had previously regarded sanitary inspectors as persecutors. He linked Overare's good performance to "the soundness of the training given at the course for Sanitary Inspectors at Ibadan".[113]

Popularising Public Health Policy

Education was another principal function of the NA's health personnel. During the tours of sanitary inspectors and dispensary attendants to nearby communities, schools and other public places for vaccination and house-to-house inspection, they gave lectures on modern methods of sanitation and advised people to come forward for treatment at the attack of any epidemic or endemic diseases. In the Aboh division, for example, the attendants at Abbi visited Emu, Orogun, Ezionum, Amai and Ogume while the one at Utaghauno toured Afor, Ossissa, Onicha, Akeko and Abedei twice monthly for vaccinations and enlightenment campaigns.[114]

The authorities recognised women's central role in implementing and adopting knowledge about health and sanitation in the domestic environment. Thus the adult education for women formed an important vehicle for inculcating modern health policy. The NAs initiated Rural Women Education Schemes that

113. Annual Report, Warri Province, 1939/1940, (1939), pp.19-20.

114. Annual Report, Aboh Division, 1936, p.23.

recognised the importance of women in the house hold and economy. In the Urhobo division, for example, Mrs. Isobel Pender, wife of the District Officer inaugurated the first centre at Ughelli in 1937, introducing courses in domestic science and crafts. By the end of the year she taught a permanent class of twenty-five women who attended classes twice weekly. Each clan in the division was meant to constitute a branch affiliated do the divisional centre while village branches affiliated to the clan branches. Only two clan branches commenced that year at Olomoro and Ewu.[115] By 1941 most clans in the division had founded and affiliated their centres to the central body with a total membership of 205.[116]

In early November, 1941 Mrs. Pender organised a course of lectures for thirty-three representatives of the branches at Ughelli. She invited dispensers, doctors, sanitary inspectors and crafts men and women to deliver lectures. Dr. J.T. Sorley, wife of the Medical Officer, lectured on maternal and childcare. Overare, Sanitaty Inspector lectured on sanitation emphasising personal and house-hold cleanliness. Mr. Muoghereh, the NA dispenser, discussed the importance of dispensaries in treating simple ailments. Other lectures centred on domestic duties such as washing and ironing of clothes, weaving, sewing, knitting, basket making, simple embroidery and stitching. Table XXII below was the time table for the course of lectures showing timing of the various activities.

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115. Annual Report, Warri Province, 1936/1937, (1937), p.11.

116. The following clans had branches of RWEC, Jeremi, Olomu, Ughelli, Owe, Oleh, Olomoro, Igbide, Aviara, Okparabe, Osere, Usoro, Effurun-Otor, Agbedu, Aravoarien, Everen, Ewu and Iyede. Annual Report, Warri Province, 1941 Onwards (1941), p.10.

Table XXII

Time-Table for the Six Day Course under Rural Women Education Scheme Urhobo Division Ughelli, Nov.10-15, 1941.

	8.30 a.m. - 9.00 a.m.	**9 00 a.m. - 10.00 a.m.**	**10.00 a.m. - 12.00 noon**	**3.00 p.m. - 5.00 p.m.**
Monday	House Work	Visit dispensary for demonstration	Lecture on the War. Sewing first steps	Sewing
Tuesday	House Work	Knitting first steps	Lecture on NA and Ante-Natal care	Knitting
Wednesday	House Work	Visit Dispensary. Lecture on uses of Dispensaries	Demonstration of Weaving Cloth-Patching	Demonstration of Basket making
Thursday	House Work	Sewing Hem-stitching	Lecture on Child Welfare Darning	Sewing, simple embroidery stitches
Friday	House Work	Visit Dispensary. Lecture smallpox and need for vaccination	Sewing, Button hole making Binding and finishing seams	Lecture on sanitation followed by a tour of the station to inspect incinerator
Saturday	House Work	Washing of clothes	Lecture on child welfare Demonstration of weaving cloth	Ironing clothes

Lecturers: Mrs. Sorely, Mrs. Pender, Mr. W.E. Otobo, Mr. Muoghereh, Mr. Overare

Demonstrators: Mrs. Dominic, Mrs. Wakezu, Mr. Kanu. On Saturday evening the class invited to visit the Senior District Officer's bungalow at 6.30 where they will be shown over the house and see electric light, refrigerator etc.

Source: NAI, MH (Fed.) 1/13987A: Colonial Development and Welfare Issues 1940-1953, p.26D.

The programme comprised activities that women found enjoyable and remunerative because they conicided with their traditional domestic roles in the society. They learned some modern techniques of housewifery, hygiene and childcare without being alienated from their culture. The Rural Women Education Centres (RWEC) became vehicles through which some Nigerian women who were not privileged to attend formal schools during this period acquired limited Western education, ideas and techniques. The emergent educated elite encouraged their fiancees and wives to attend these centres.[117]

This scheme accelerated the spread and acceptance of western ideas and methods of health care. Wives and mothers incorporated what they learned in carrying out their domestic responsibilities. They extended new ideas to their co-wives, children, husbands and clan members who in turn spread the gospel of hygiene to their village branches. Although a minority at this time received formal education, they enjoyed the RWEC's courses and quickly embraced knowledge they regarded as beneficial to their families. Many were traditional midwives, "all of whom except one had had no European training whatsoever and merely followed the heriditary practices of their people". The one exception received training at the CMS maternity centre at Bethel where the mission initiated its own scheme of RWEC.[118] Later, two of the traditional midwives, sponsored by the

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117. LaRay Denzer, "Domestic Science Training in Colonial Yorubaland Nigeria" in K.T. Hausen ed. *African Encounters with Domesticity*. (New Brunswick, NJ: Rugers University Press, 1992), pp.120-121.

118. NAI, MH/Fed/1/1/3987[A]: Report by DO Urhobo Div. on RWEC to Resident WP 30-11-41.

NA, took a months training at the Warri Hospital.[119] This represented a significant change. If the traditional midwife or healer, the embodiment of tradition, had accepted the efficacy of modern methods, her clients must follow. These midwives responded to the socio-economic environment marked by rapid social change.

Besides, the NAs embarked on a scheme of formal training of their health and medical personnel. They had the responsibility of training or recruiting dispensary attendants, midwives and sanitary inspectors for their medical and health institutions. We recall that lack of dispensary attendants delayed the opening of dispensaries in the Warri province because the trainees did not complete their training at the Sapele hospital before 1930.[120] Having no qualified personnel to recruit they resorted to training their people with the belief that they would be more acceptable to the rural dwellers than people from other culture areas as Ormsby Gore envisaged. The Aboh NA, sent three persons: Messrs Gregory Erutaya, Daniel Urueregbe and Peter Esumei, to train as dispensary attendants at Sapele Hospital between 1931 and 1933.[121] This type of training did not, however, satisfy the standard of competence required by the Ministry of Health. Hence this calibre of workers were classified as layworkers, because they did not qualify to register as professional nurses, midwives and dispensers.[122] This

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119. Ibid., p.26[C].

120. Annual Report, Warri Province, 1930, p.292.

121. Annual Report, Aboh Division, NA Dispensaries, 1932, pp.44 and 282.

122. NAI, MH/Fed/I/113987[G]. p.2: Memo Senior Leprosy Officer, Enugu to E. Muir Sec. BELRA 16-11-46.

necessitated the emphasis the colonial state laid on the inspection of their work by medical officers and even administrative officers.[123] Nevertheless, they played a vital role in the development of modern medicine and its extension into the rural areas.

(D) Co-operation between the Missions and the State

One of the major motives of the Christian missions in establishing medical work was the obvious lack of health services in rural areas. In many places mission medical work preceeded government health services.[124] By 1930, the CMS had located their initial health work in rural communities in Isoko and Urhobo land that had had no government or NA medical centres. Thus, they complemented the health services of the different arms of government by extension into uncovered areas. We have shown earlier (Table XII) how the colonial state encouraged their medical work through grants-in-aid.

Obviously, missionary medical work also had an evangelical motive. Successful treatment often led to conversion.[125] This motive dominated the thinking of the RCM authorities at Asaba in 1933 when they conjectured that if they failed to recruit a Roman Catholic medical doctor for the Ossiomo Leper Settlement, it must be handed over to a "Protestant Body" and might result in "a

123. Annual Report, Aboh Division, NA Dispensaries, 1932, p.105.

124. *Adeloye, The African Pioneers*, pp.43 and 45.

125. Ayandele, *The Missionary Impact on Modern Nigeria*, p.285.

loss of hundreds of lepers to the Catholic cause".[126] Eventually, the RCM took direct responsibility for the religious and social work in the settlement consequent upon recruiting a Roman Catholic medical officer for the centre. It opened a Church in 1933 and later a school. Other social activities such as sports, clubs and concerts came under the management and supervision of the Catholic mission.[127]

The CMS went directly into medical activities in the province. The Niger Diocese of the CMS, with headquarters at Onitsha and medical headquarters at Iyienu hosptial, developed a programme for rural health services through the establishment of dispensaries and maternity homes.[128] It started in 1926, with the opening of a maternity wing at the Iyienu hosptial and extended to all parts of the Diocese including parts of Warri Province.[129]

In April 1930, a qualified Nursing Sister, Miss Dorothy Jewitt, opened a CMS medical centre at Bethel, comprising a maternity, a dispensary, a clinic for motherless babies and a training programme for illitrate women as extension agents in neighbouring clans.[130] By the end of 1933, the CMS had opened four new

126. NAI, RCM BD Vol. II 6/1 p.30: RCM Asaba to P.W. Ogorman Guild of St. Luke, Cosmass & Damian Middlesex 20-6-33.

127. NAI, MH/Fed/1/1/3987^{C} p.1: Memo DMS to CSG 2-4-40.

128. NAI, MH (Fed) 1/1/6038^{F}: Annual Medical and Sanitary Report, Mission Activities, p.7^{A}.

129. Schram, *A History of Nigerian Health Services,* p.223; Erivwo, *Traditional Religion and Christianity in Nigeria*, pp.89-91.

130. NAI, CSO 26/2/11857 Vol. VIII: Annual Report, Warri Province, 1930, pp.317-318; O. Ikime, *The Isoko People: A Historical Survey* (Ibadan: Ibadan University Press, 1972, pp.79-80.

centres in Uwerun, Ozoro, Ughelli and Enwe.[131] Six years later it set up a maternity home at Igbudu.[132] Meanwhile, the maternity home at Bethel was transferred to Oleh in the same year and in 1941 the entire medical work of the CMS at Bethel transferred to Oleh the parish headquarters.[133]

The CMS recognised, even before the NAs, the importance of women in domestic responsibilities and the need to train them in rules of hygiene and sanitation as disease prevention measures. In addition to training illitrate women on child-delivery which started in Bethel in 1930, it opened a vocational training centre for girls at Oleh the same year. These centres served exactly the same objectives and achieved corresponding successes as the RWEC of the NAs discussed earlier. In fact, the NAs drew inspiration for their RWE programmes from the success of the CMS centres. Laray Denzer has elaborated on the significance of these centres on educating rural women and shown that by 1937, the year the NAs inaugurated their first RWECs, the CMS had established twenty five such centres in the Delta area alone.[134] Many of the girls trained in these centres did not only serve their homes and communities they also trained other girls. It was a popular practice for Church members and teachers to send their

131. Annual Report, Warri Province, 1933, p.34.

132. NAI, Ughelli Dist. 1/289 p.42: Hubbard, Ag. Supt. CMS to DO Urhobo Div. 10-10-34.

133. Ikime, *The Isoko People*, p.81.

134. Denzer, p.120.

wives to their pastors and others whose wives trained at the CMS vocational centres for similar training.[135]

To exact direct influence on surrounding communities the CMS at Bethel organised girls to undertake demonstration lessons on cleaning cooking utencils, surroundings and public places for the people.[136] Furthermore, the CMS incorporated knowledge of health measures into its regular women programmes. It required women seeking admission into the Mothers' Union and Women's Guild to display such knowledge at oral examinations (catechism) which they must pass in order to qualify.[137] These efforts to educate the rural populace on health measures challenge the view of Dennis A. Itayvyar that the missions did not give priority attention to disease prevention measures.[138]

The opening of these modern health centres constituted events of great moment to the villagers who had started to conceive them as positive steps towards development. Missions were highly skilled in staging effective ceremonies to mark such events. O. Ikime aptly describes how, "singing, drumming, dancing and general rejoicing" marked the arrival of the first two medical and social

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135. Ikime, *The Isoko People*, pp.80-81; Interview, Mabel Nwabuoku, Aged 55, Caterer and Wife of a Retired Anglican Archdeacon, Abraka, 24 April, 1995.

136. Ikimi, *The Isoko People*, pp,.80-81.

137. Interview, Nwabuoku.

138. Dennis A. Itayvyar, "The colonial origins of Health Care Services: The Nigerian Example" in *The Political Economy of Health in Africa* eds. Toyin Falola and Dennis Itayvyar (Ohio: Ohio University Centre for International Studies, 1992), p.69.

workers at Bethel. Popular participation encouraged acceptance of new measures. We have earlier shown how pregnant women went for ante-natal and post-natal treatment and deliveries. The dispensary section attended to 5,645 cases between April and December 1930 beating the record of Ughara and Orerokpe dispensaries opened exactly a year later (see note 78 this chapter). Sixty women volunteered to train as auxiliary nurses. Meanwhile, other Church women and girls engaged in educating the rural populace on disease prevention measures.[139] Thus, the CMS played a crucial role in the initial institution of modern medical and health services in the rural communities in the Warri Province.

(E) Private Proprietors

Commercial companies also contributed to the expansion of modern medical facilities during this period. The government encouraged them through regulation of their services. Their medical activities and infact those of the Christian Missions functioned with permit under the Poisons and Pharmacy Ordinance 1936 and later under the Private Hospitals Ordinance No. 52 of 1945. The ordinances required all private medical practitioners: individuals, communities, companies and Christian missions to apply for registration in a prescribed form through their District Officers and Residents to the Director of Medical Services. On approval, and after registration, their institutions came under the regular

139. Ikime, *The Isoko People*, p.79; Annual Report, Warri Province, 1930, pp.317-318.

supervision of the government medical services. Their certificates of registration could be withdrawn if they failed, at any point, to meet good standards of management.[140]

The employment of a female welfare worker in 1942 by the Sapele Rubber Estate marked the beginning of private medical and health services by a commercial company in the Warri Province. Her duties included supervision of the living conditions of labourers and advising them on environmental sanitation.[141] Two years later, the United African Company (UAC) opened a dispensary and an infectious disease unit at Burutu. They were visited three times weekly by the medical officer at Forcados.[142] Though these institutions primarily served the company workers and thier families, they also treated non-company workers who paid for their treatment.[143]

Another area of private practice that fostered the expansion of modern medical services in the province comprised the private practice by medical officers and other workers in government service. We have discussed how the medical officer of Forcados, visited villages to treat yaws and other ailments on private practice. The activities of Coker, however, aroused criticism and suspicion. It was alleged that he seized the licences of the dispensary attendants in Ijo Division

140. NAI, War Prof., WP 370 p.3: SMO Enugu to Resident Warri 20-1-45; War prof. 1, WP 754 p.2: C. Wilson DMS to SNPs Kaduna, 25-2-46.

141. Annual Report, Warri Province, 1941 Onwards (1942), p.6.

142. Annual Report, Warri Province, 1944, p.15.

143. Interview, Obagbinoko.

in order to monopolise private practice. They also charged that he neglected official duties and used the hospitals and dispensaries for private practice.[144] These allegations reopened the debate on private practice by medical doctors in government service. The Director of Medical Services, Harkness, directed that private practice could continue in hospitals where the abuse was minimal but prohibited in the NA dispensaries where the rate of abuse was high. On the alternative, the Resident of Warri Province, Robert Leonard Bowen, realising the importance of private practice for disease control in his province suggested fixing prices of drugs which the medical officers should account for or the drugs could be stored at the dispensaries and issued to the medical officers for use only in the dispensaries.[145] Finally, the senior medical officer Enugu, Phillip Hugh Rawson, ruled that the practice before Samuel Layinka Adodeji Manuwa left in 1938 whereby the medical officers used the dispensary stocks and paid the fees into the NA revenue should be reverted to because it proved effective and satisfactory.[146]

The demand for private medical attention of medical officers by villagers provides insight into the degree of acceptance of modern medicine within this period, especially for the treatment of such diseases as yaws and smallpox for which it had proved very effective. It also indicates that government medical facilities had not satisfied the health needs of the populace. These facts made

144. NAI, War prof 1, WP 437 pp.16-17: Resident WP to SMO Enugu 23-12-41.

145. NAI, War prof 1, WP 437, p.3: Ag. DMS to SWPs Ibadan 21-1-41.

146. NAI, War prof 1, WP 437, p.7: SMO Enugu to Resident Warri 16-9-41.

private practice expedient because it facilitated the extension of medical services to most Delta people.

(F) Assessment of Policy and Implementation

Although there had been significant progress in instituting rural medical services with the opening of the foregoing institutions, the bulk of medical services concentrated in the towns and the NA and some clan headquarters where there was a large clientele among government and other workers. Except for the CMS medical work at Bethel and its branches the rest of the rural communities remained almost untouched by the government services. Only during monthly tours by sanitary inspectors or dispensary attendants did these people have contact with new policies, often as subjects of enforcement. Some vital areas of modern medical services only received little attention. Not until December 1944 did the Urhobo NA open a maternity home. Except for Warri, other hospitals had not fully developed maternity services. They gave only ante-natal treatment.[147]

Sanitation and other disease control measures needed extension to the rural populace. Only on special occasions did campaigns for the eradication of mosquitoes and vaccination against smallpox go beyond the towns, the NA headquarters and the medical centres. Except for the two wells opened in Kwale division in 1931 all other water schemes concentrated in the towns.

Medical services still suffered from inadequate staffing. A lone medical doctor still served all the hospitals in each town, except Warri, which had two,[148]

147. Annual Report, Warri Province, 1944, p.4.

148. Annual Report, Warri Province, 1934, p.21.

even when the work-load of medical officers had increased. Whereas in 1929, a medical officer was responsible only for inspecting government dispensaries, prisons and stations in addition to hospital duties; in 1944 his or her duties included inspecting NA and mission dispensaries and maternitiy homes among other duties. This made his task not merely difficult but nearly impossible. For example, in 1939, the medical officer at Sapele visited Aboh division only twice between August and December whereas he was supposed to visit monthly. Yet he could not inspect any medical establishment because he went to court to give evidence.[149] The dispensary at Aboh opened in May 1934 had its first inspection in September 1940.[150] In the Ijo division the medical officer at Forcados had, in addition, six NA and two company dispensaries to inspect. The terrain and lack of transport facilities further complicated his task. Consequently, some dispensaries remained uninspected for several months.[151]

Shortage of staff in the NA dispensaries also constituted a serious problem to their work. Theirs was both qualitative and quantitative. We recall that some dispensary attendants, sanitary inspectors and nurses received emergency training in the nearby hospitals and therefore were not qualified for registration as professional dispensers, sanitary inspectors, midwives or nurses. This limitation

149. NAI, Kwale Dist 1/141 Vol. VII: Annual Report, Aboh Division, 1939, p.41.

150. Annual Report, Aboh Division, 1940, p.30.

151. NAI, War prof 1, WP 74/4 p.4: DO Western Ijo Division to Resident Warri 13-11-46.

necessitated the regular inspections of their work by medical officers and even administrative officers. Lack of adequate training resulted in inefficiency which discouraged some patients from attending these institutions. Hence, attendance and revenue collected from the dispensaries declined. Besides, the NA did not employ enough workers within this period. For instance, when S. K. Ekiyor wanted to resign his appointment as a dispensary attendant the NA rejected his resignation because it might mean "closing down the Sagbama dispensary".[152] The NA had not employed a sufficient number of dispensary attendants to enable them to go on annual leave.

Shortage of drugs also posed a serious problem. In 1934, the district officer Kwale Reuben John Hook, reported on the work of the vaccinator incharge of the government dispensary, Kwale, Mr. P. Aghagbon, and remarked that

> His stock of medicament, however, is so inadequate to treat even a part of the people who came for attention and it is necessary to limit his attention strictly to the more serious cases in the station itself.[153]

A similar report ten years later by the Resident, R.L. Bowen, identified a general dearth of drugs in the province.[154] That situation detracted from the effective services of the institutions.

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152. Ibid., p.1.

153. Annual Report, Aboh Division, 1934, p.41.

154. Annual Report, Warri Province, 1941 Onwards, (1944), p.8.

Undoubtedly, inadequate staffing and shortage of drugs resulted from inadequate funding. The British colonial policy of self sufficiency by which economic and social services were provided with funds raised in the colonies was still largely in force. The financial assistance of £1 million the British Government undertook to grant to Nigeria annually as provided in the Colonial Development Act of 1929 dwindled considerably as a result of the depression of the 1930s and the global war. Details of what the British Government could afford within the period have been given in Table XI. These factors: the depression and the second world war also depreciated Nigeria's resources.[155] Consequently, revenue allocated to medical and health services in Nigeria remained very meagre (see table XXIII below).

155. M. Crowder, *West Africa Under Colonial Rule* (London: Hutchinson and Co., 1968), p.323-324 and 503.

Table XXIII

Total Expenditures on Medical and Health Services, Nigeria, 1930-1944

Year	Expenditure
1930/31	485,940
1031/32	441,590
1932/33	384,743
1933/34	391,339
1934/35	384,672
1935/36	377,671
1936/37	387,600
1937/38	462,629
1938/39	458,385
1939/40	442,403
1940/41	450,378
1941/42	445,676
1942/43	522,188
1943/44	642,131
1944/45	676,636

Source: Annual Report, Nigeria, 1945-46, p.91

Most of the period allocations fell below that of 1929 (£473,137). In 1939, it amounted to five pence per capita while Ghana's per capita expenditure on health the same year amounted to two shillings.[156] By 1944, it had increased to only six pence per head of Nigeria's population. The Director of Medical and Health Services, Harkness, confessed in 1944, that it was the lowest budgetary

156. Caldwell, "The Social Repercussion of Colonial Rule, p.476.

estimate on Medical and Health Services in the colonial empire.[157] Likewise, the NAs allocated only between five and nine percent of their revenue to medical and health services; while they devoted about fifteen percent of their revenue to educational programmes.[158]

These structural and administrative problems created situations which detracted from effective modern medical services. Lack of funds led to the introduction of dispensary fees which discouraged most people who stopped attending dispensaries for treatment. Unqualified and inefficient medical staff caused some people to stay away from some medical institutions. Inspite of these inadequacies the number of people seeking modern health services: the Christians, the educated class, company and government workers continued to increase. Even the traditionalists had started to appreciate modern medicine. To satisfy these needs the British Government decided to change its colonial policy. It enacted the Colonial Development Acts of 1940 and 1945 respectively which aimed to expand modern social services in the colonial territories in an unprecedented scale. It took effect from 1945. The extent to which the implementation of the provisions of these acts expanded modern medical service in the Warri Province and solved most of these problems will be the object of the next chapter.

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157. Ten Year Plan, p.68.

158. Annual Reports: Aboh Division, 1941, pp.73 and 77; 1942, pp.129 and 131.

CHAPTER FOUR

POST WORLD WAR II DEVELOPMENT OF MEDICAL SERVICES 1945-1950

A. The Colonial Development and Welfare Scheme

With the coming to power of the Labour Party Government of Clement Atlee in Britain in 1945, a new era dawned in the social and economic development of the colonial territories. The Labour Party favoured Welfarism, arguing that private economic investment represented exploitation whilst state-sponsored enterprises did not. This policy guided post-war reconstruction in Britain.[1] Agitations in the colonies, including the Warri Province, predating the Second World War resulted in extending this policy to the colonies in 1945.[2] Violent agitations in the West Indies prompted the appointment of a royal commission there in 1938 for investigation and recommendations.

The commission deplored the poor state of social and economic services in the West Indies and recommended a change of the British imperial policy. Government adopted the proposals and enacted the colonial Welfare Act of 1940 enunciating its preparedness to finance social and economic development programmes in her colonies.[3] But no positive action followed the Act because of

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1. Lawrence James, *The Rise and Fall of the British Empire* (London: Little Brown and Co., 1944), pp.527-528.

2. See fn. 15, chap. three.

3. James S. Coleman, *Nigeria Background to Nationalism* (Benin City: Broburg & Wistrom, 1986), p.31.

the war. This inactivity led Michael Crowder to the conclusion that the 1940 Welfare Act represented a ploy to secure the loyalty and support of the colonies in the ongoing global conflict.[4]

The 1945 Colonial Development and Welfare Act, however, actualised the dreams of the 1940 Act. It provided 120 million pounds to finance social and economic projects in the British colonies. Nigeria received about a quarter of the total direct allocations for British colonies, twenty-three out of eighty-five million pounds. Thus, the British government eventually abandoned the former British colonial policy of economic "self sufficiency" in favour of state sponsored socio-economic development. As the estimate for Nigeria's Ten Year Development Plan amounted to fifty-five million pounds the Nigerian government had to augment the British government's free grants with thirty-two million pounds from its own funds and loans. Health programmes received an allocation of £8,323,327 while a separate allocation for leprosy control for the first five years amounted to £453,870.[5]

The Director of Medical and Health Services Nigeria, Dr. Harkness, and his deputy, Dr. George Blyth Walker, drafted the scheme for their department emphasising the expansion of hospital and dispensary facilities, preventive

4. M. Crowder, *West Africa Under Colonial Rule* (London: Hutchinson & Co., 1968), p.503.

5. Nigeria, Legislative Council Debates, 23rd Session, 13 December, 1945, pp.122-123.

measures and especially the expansion of rural medical services.[6] To accomplish these ends they outlined the following projects and programmes:

(1) To establish "one or more first class hospitals with full facilities for scientific investigation and treatment of diseases" in each province to serve the town in which it was situated and also receive patients referred to it. They envisaged a bed ratio of one to 2000 as against one to about 5000 before the plan.

(2) To provide Mobile Field Units to deal promptly with serious outbreaks of infectious diseases and institute mass treatment campaigns against various endemic diseases.

(3) To set up Rural Health Centres to undertake all rural medical services including supervision of NA Dispensaries and Maternity Homes.

(4) To establish Maternity Hospitals and Homes and train midwives.

(5) To train medical personnel of all cadres especially Nigerians.

(6) To institute a Government Leprosy Service to take charge of leprosy control in the country through the establishment of leper settlements, villages and clinics.[7]

The Ten Year Plan of Development and Welfare for Nigeria, presented to the Legislative Council on 13 December 1945, received final approval after eight weeks consideration, on 7 February 1946. The plan comprised two five year

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6. A Ten Year Plan of Develolpment and Welfare for Nigeria (Lagos: Government Printer, 1946), p.68.

7. Ibid. p.68

periods, with detailed schemes drawn for the first five years at which time it would be reviewed. This chapter focuses on the implementation of health programmes in the Warri Province during the first phase (1945-1950).

B. Post War Development of Medical and Health Schemes in Warri Province

(1) Hospital and Health Centre Projects

The provincial Development Plan called for the expansion and consolidation of all the existing general hospitals in the province (Warri, Sapele and Forcados) and the establishment of a new general hospital and a health centre. It earmarked the Warri General Hospital as a "first class hospital with full facilities for scientific observation and treatment of diseases" in the province. Futhermore, it proposed bed increases of about 600 percent for Warri and 200 percent each for Sapele and Forcados hospitals. The new general hospital proposed for Obetim Kwale represented the first government hospital sited in a rural area. It would no doubt satisfy the aspirations of those members of the rural Delta elite, discussed earlier, inclined to seeking "more skilled treatment" from doctors.[8] Table twenty

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8. see fn.80 chap. three.

four below shows the approved number of beds for the existing and the new hospitals.

Table XXIV

Approved Number of Beds for Old and New Hospitals in Warri Province in the Ten-Year Development Plan

Hospital	Existing Beds	Proposed No. of Beds	Beds Increase
Warri	26	176	150
Sapele	31	91	60
Forcados	24	60	36
Kwale	-	60	60

Source: NAI, PX/F1, A Ten Year Plan of Development and Welfare for Nigeria: Paper laid on the table of the Legislative Council on 13 December 1945 as sessional paper No. 24 as amended by select committee of the Council on 7 February 1946 (Lagos: Government Printer, 1946), p.79.

The opening of Rural Health Centres represented a new idea for health care delivery introduced by the Development Plan. They were to undertake dispensary and maternity services in one institution under the management of a qualified medical doctor. The doctor incharge had the responsibility to supervise all dispensaries and maternity homes as well as all public health services in his district. The centres were also to serve as models for the future NA medical services

especially the combination of dispensary and maternity work in one centre.[9] The Warri Province got a share of one centre located at Ughelli to serve mainly the rural communities among the Urhobo and Isoko peoples. Again this centre would satisfy the quest for the attention of medical doctors among these rural dwellers.

In addition to these permanent treatment centres the Plan proposed the establishment of a Mobile field Unit to serve the Benin and Warri Provinces in dealing promptly with outbreaks of infectious diseases. It also had the responsibility of carrying out mass treatment campaigns against endemic diseases as well as executing all disease prevention measures in both urban and rural areas. Its other duties included health and nutrition surveys.[10]

Inadequate planning and preparations frustrated the execution of these very momentous projects within this phase. Except for the Warri hosptial where work commenced on the X-ray Unit and the Sanitation Block in 1950 work did not commence on other projects due to lack of equipment and skilled personnel. Most of the necessary equipment needed for the projects and lorries for distribution arrived in Nigeria in 1950. It still took time to provide body-building for the vehicles before they could embark on distribution of equipment to project sites.[11]

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9. Ten Year Plan, p.70.

10. Ibid., p.69.

11. Annual Reports, Development and Welfare Schemes, 1945-46, p.3; 1949-50, p.85.

Recruitment of high level skilled man-power required for the execution of projects also proved very difficult. We illustrate this with the staffing position for the Water Scheme projects tabulated below (Table twenty-five).

Table XXV

Required and Available Staff for Water Supply Schemes in Nigeria 1948/49 and 1949/50

Categories of Staff	Authorised/ No. of Staff	No Available 1948/49	No Available 1949/50
Drillers	13	8	8
Inspectors	47	28	24
Executive Engineers	12	1	2
Special Drilling Engineers	4	2	1
Mechanical Engineers	1	-	1
Administrative Assistants	1	-	1
Store Keeper	1	1	1

Source : Annual Report, Development and Welfare Schemes 1949/50 (Lagos: Government Printer, 1950), p.85.

No mechanical engineers and administrative assistants had been recruited by the end of 1948, while only about fifty percent of drillers, inspectors and special drilling engineers and about seventeen percent of executive engineers were available in Nigeria in 1950. The fact that most water scheme projects reached advanced stages of completion by the end of 1950, irrespective of the above staffing position, suggests that staffing position for other projects where work did

not start at all might be helpless.[12] The effect was that most projects in the Plan did not take off until after the first phase.

2. Public Health Schemes

Urban and Rural Water Schemes

Policy makers emphasised water supplies and treatment to prevent water-borne diseases and enhance sanitation measures. Hence the plan provided for Urban and Rural Water Schemes. For Urban Water projects the government gave, from the Development Fund, grants to cover thirty percent of the cost of construction, full cost of staff, plant, instruments and vehicles. The remaining seventy percent would be given as loans which the urban communities would repay at an interest rate of three and a half percent for a period of twenty years.[13]

In April 1946, the Warri Town Council resolved to undertake a water supply project under this scheme. The Warri Urban Water project, estimated to cost £15,000 for construction, and £1,500 for annual maintenance, covered the whole township as well as Odio and Okere areas.[14] The scheme proposed to supply 10,000 gallons of water per hour for ten hours a day for a population of 15,000, making little allowance for future increase of population before the end of the plan period because Warri's population at the time amounted to 13,970. It also proposed to take care of future increases in population by increasing pumping

12. NAI, War prof 1, W.P. 235/1 Vol. IV: Annual Report, Warri Province, 1950-51, pp.40-43.

13. Annual Report, Development and Welfare Scheme 1945-46, p.9.

14. NAI, War prof 1, WP 1200, p.41: Minutes of Town Board 25-4-46.

hours per day.[15] The Plan did not, however, envisage the demand by other outlying communities, like the local population of Odio district, for extension of water supply to them. Increased pumping hours per day could not take care of these areas and the rapid expansion of population in the main township as pumping hours were limited to twenty-one hours per day in order to preserve the engines.[16] Thus, even before the completion of the projects and the end of the plan period demand outstripped supply. By 1950, work had reached an advanced stage of completion with only the high lift boosting pumping machine yet to be installed.[17]

Some townships rejected such water schemes. Earlier, the Sapele community complained that it could not finance a pipe-borne water scheme. Urban communites that rejected, or for whom the government did not approve urban water schemes opted for water supply under the Rural Water Scheme, details of which will be discussed. The Public Works Department sank two additional wells in Sapele in 1947, ten in 1949, and also in Forcados and Burutu where it provided additional tanks.[18]

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15. Ibid., p.7: Proposal for Warri Water Supply (No date) (No Author).

16. Ibid., p.192: Memo, PWD Warri to Director PWD Western Region, 4-1-54; p.222: Memo, PWD Warri to Sec. Urban District Council Warri 23-11-56.

17. Annual Report, PWD, 1950-1951, p.40; Annual Report, Warri Province, 1950, p.95.

18. NAI, Sap Dist, 1/1/234 p.3: Memo, Provincial Engineer to DO Sapele 13-6-49.

Rural Water Supply Scheme

The Development Plan provided for a less capital intensive water projects for the rural dwellers who were not required to make any financial contributions. It proposed to sink 7,200 new wells and renovate about the same number of old ones, where they existed, at the same cost of eighty three pounds per well within the first phase of the scheme.[19] The Public Works Department, under the supervision of the provincial engineer, sank the wells at sites recommended by the divisional councils and approved by the District Officers, while the Development Fund met the entire cost of sinking wells under this scheme.[20]

By the end of 1946 the various divisions had earmarked sites for wells in their areas. The Urhobo divisional executive council at its meeting of 23 March 1945, approved sites at the following villages: Usoro, Enwe, Uwerun, Usere, Emede, Ewu, Oleh, Igbide, Evereni, Olomoro, Owe, Iyede, Kakpamre, Otu-Jeremi and Ukan. At another meeting on 3 December 1946, it confirmed these sites and approved the sinking of an additional well at the divisional council premises.[21] Shortage of staff and materials delayed commencement of work until April 1948 when work started at eighteen sites in the Jekri-Sobo division and at twenty-five other sites in May. Materials for twenty-five wells were dispatched to Aboh

19. NAI, Ugel Dist 1/825/2, p.87: Memo CSG to Sec. Western Provinces 15-7-49.

20. NAI, War prof 1, W.P. 1200, p.41: Extracts from Warri Township Advisory Board Meeting 21-5-48.

21. NAI, Ughel Dist 1/825/2, p.6: Minutes Urhobo Divisional Council 3-12-46.

division while fourteen were sunk in Urhobo division.[22] In 1950 the Public Works Department started an experiment on the suitability of tube wells which were being proposed for the next phase.[23] By the end of that year a reasonable number of wells had been sunk in the province. In Ijo division seventy out of one hundred had been completed. In Urhobo divisions eighty-five ring wells and seven tube wells had been sunk.[24] The water supply scheme represented one of the few projects in which considerable success was achieved in their completion.

The Delta peoples showed great enthusiasm towards the completion of their water schemes and made various contributions. Their willingness to make financial and other contributions reflected their acceptance of the new measures. This indicated the success of the enlightenment campaigns and propaganda concerning clean environments and personal hygiene in which water constituted an indispensable element in maintaining. The Warri Township Council and dwellers agreed to shoulder the responsibility for the repayment of a loan of £10,500 with an interest of three and a half percent over a period of twenty years in addition to

22. NAI, Ughel Dist 1/1354, p.26: Warri Provincial Engineer to Regional Deputy Director PWD 26-4-48.

23. NAI, Ughel 1/825/2, p.118: Minutes Isoko NA. Council 19-1-51; p.123: Memo, Urhobo District NA List of Wells 31-1-51.

24. NAI, War prof 1, WP 1200, p.39: Minutes Urhobo Divisional Executive Council 1946; NAI, War prof 1, WP 146^{G}: annual Report, Development and Welfare Schemes 1946-49, p.48; NAI, Ughel Dist 1/1264/1: Annual Report, Development and Welfare Schemes 1950-51, p.9; NAI, Ijaw (W) 4, WI 335 Vol. 1: Annual Report, Ijaw Division, 1949, p.238.

annual maintenance cost of £1,500.[25] Even the rural dwellers, who were not officially required to make any contributions, supplied sand, stored the cement and cleared the sites. Such communal manual work facilitated the execution of projects in such communities as Oha, Okpara-in-land, Owu-in-land and Kokori-in-land, where the people acted promptly while lack of it delayed work at Effurun where the people were reluctant to supply sand.[26] The provincial authorities encouraged such community efforts so as to hasten the execution of projects as well as to conserve funds and increase the number of wells.[27]

The provision of wells became a contentious issue generating protests anchored on different principles by various groups. The Uwerun clan could not understand why it should have a share of six wells while its neighbouring clan Everemi, had ten. It based its protest on either the traditional method of equal distribution of shares among different units: families, villages and clans or on population. On the other hand the Urhobo division based its protest mainly on population, which of course the Plan enunciated, a well for about 500 persons. It wanted "a lion's share" because it constituted two-thirds of the Province in both population and land area. Some modern institutions, the CMS mission, the Aviara Parish of the RCM and the Elementatry Training Centre Oleh just wanted wells

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25. NAI, War prof 1, WP 1200, p.87[A]: Secretary Western Provinces to Resident Warri 21-3-51.

26. NAI, Ughel Dist 1/1354, p.22: DO Warri to Water Works Inspector 18-4-48.

27. NAI, Ughel Dist 1/825/2, p.24: DO Urhobo to Central NA Urhobo Division 4-5-48.

to serve their individual compounds.[28] These protests indicated that the Delta peoples had come to appreciate the importance of safe and sufficient water supplies hence the provision of wells had become an area of contestation. They also brought to the fore a conflict between tradition and modernity on the criterion for sharing amenities. A problem that needed serious consideration in the sharing of amenities.

(b) Urban Sanitation

The Development Plan emphasised preventive measures, pointing out that the effort of the medical institutions would be largely wasted if the convalescents returned to the same insanitary conditions that caused their disease.[29] The provincial administration strenghtened and extended all existing sanitary measures in the towns before the inauguration of the Development Plan, especially the systems of disposing human waste, inspection of premises and public places. Between 1946 and 1950 the authorities augmented and upgraded the sanitary staff by appointing a Health Visitor for Warri, a Senior Sanitary Superintendent for the province, and a Sanitary Inspector for the government station at Obetim where only a vaccinator had been incharge.[30] These officers set out to enforce the public

28. Ibid., pp.95, 118, 137, 140: Ag. DO Urhobo to Urhobo NA Council Ughelli 22-11-49; Obrutse for Everemi Community to DO Urhobo 6-3-51. Minutes Isoko Dist NA Council 19-1-51; Sister Supervisor CMS to DO Urhobo 15-3-51.

29. Ten Year Plan, p.68.

30. NAI, War prof 1, WP 235 Vol. III: Annual Report, Warri Province, 1946, Enclosure p.117, p.93; Annual Report, Warri Province, 1950, p.83.

health rules already introduced in the townships before 1945 and implement new regulations.

The provincial administration extended the use of bucket latrines, otherwise known as the conservancy system, to private individuals and companies in Sapele and Warri townships. It invited interested individuals and companies to apply for the pails and set out monthly fees for the service. Each European paid four shillings and each African two shillings and six pence. By 1948 the fees had increased to five shillings per European and three shillings per African.[31] To ease the problem of collection and transportation the NAs of Sapele and Warri acquired lorries in 1950 for the conveyance of human waste.[32]

Contractors carried out conservancy services in Sapele and Warri on the basis of monthly rates of payment. Eventually, problems erupted because of low wages paid to the labourers by the contractors. The labourers resorted to strikes to press for improved conditions of service. In November 1946 and again in June 1948, conservancy services stopped because of strikes. Only residents in government quarters where government labourers and prisoners disposed of the nightsoil were free from the nuisance of unremoved latrine pails. The Local Authority and the contractor decided to refund the users one shilling six pence per pail for the period of distrupted services.[33]

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31. NAI, Sap Dist 1/2, T. 36X: pp.860 and 709: L.A. Sapele to Senior Sanitary Inspector 23-5-47, LA Sapele to Manager UAC 9-12-46.

32. Annual Report: Warri Province, 1950, p.73.

33. NAI, Sap Dist 1/2, T36X, p.249: Public Notice by LA Sapele 28-6-48; Annual Report, Western Provinces Nigeria, 1946, p.22.

The inconvenienced public reacted sharply whenever sanitary services stopped for whatever reasons. The reactions varied: deputations by plot owners and tenants to the Local Authority; complaints by individuals and groups; articles in the press. For example, on September 14 1950, the editor of the Nigerian Standard complained that:

> For over a couple of days now the night soil labourers seem to have been on a go slow... Many premises have not been served for some days.[34]

Later, Mr. A.O.M. Arinze complained that the few public latrines in Sapele township were often closed against the public and that:

> At some critical periods the private latrines are not even cleared too and the occupants of the compounds suffer the same fate as those who have none...
> The streets are often filled with human refuse because when the public and private latrines are not cleared, some people have no alternative than to throw parcels of faeces on the streets while some resort to the river.[35]

Most town dwellers tried to fulfil their obligations by acquiring pails and paying the conservancy fees. By 1950 the contractors had as many as 1,200 pails in Sapele and 1,800 in Warri to deal with. Not many people failed to pay the fees. In Sapele, for example, defaulters were ninety-eight in November 1946, 137 in June, 115 in July and 117 in August 1947 showing that many months passed

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34. "Conservancy Contractors" *Nigerian Standard*, 14 September 1950, p.1.

35. A.O.M. Arinze, "Irregular Conservancy Services at Sapele" *Nigerian Star*, 19 September 1951, p.3.

without defaulters.[36] Yet conservancy services were never satisfactory and remained an unsolved problem in these towns till the end of the first phase of the Development Plan.

There was a steady demand for public latrines and the maintenance of old ones in the Burutu and Forcados towns as well. In 1946, the provincial administration supplied buckets to equip all public latrines in Burutu and Forcados as well as those in departmental and government residential quarters.[37] In the following year, it constructed and equipped three jetty latrines in Burutu and, in 1949, gave a grant of £231 to maintain these latrines.[38] Burutu and Forcados also campaigned for facilites to maintain a clean environment. Consequently, more dustbins were supplied for refuse collection in public places by the end of 1946 followed by the supply of more incinerators.[39]

With time some former rural communities became recognised as towns because of the presence of some modern institutions and consequently some public health rules were extended to them. Ughelli, the headquarters of the Urhobo division, with a government dispensary and a maternity home as well as a CMS

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36. NAI, Sap Dist 1/2, T. 36X, p.701: Conservancy Application Memo Bajola to DO 3-12-46; p.952: LA Sapele to Senior Sanitary Inspector, 30-8-1947; "Conservancy Contractors" *Nigerian Standard*, 14 Sept. 1950, p.1.

37. Annual Report, Warri Province, 1946, p.76.

38. Ibid, p.34; annual Report, Ijaw Division, 1949, p.218.

39. Annual Report, Warri Province, 1946, p.76.

dispensary and maternity and schools situated in it was one of the growing towns. In 1950, the provincial authorities constructed a slaughter slab at the Ughelli government station to control the slaughter of animals through inspection. This made it possible to enforce public health rules regarding the sale of meat which had been operating in the old towns.[40]

(c) Disease Control: Leprosy

As discussed earlier, the Federal Government assumed direct responsibility for the control of leprosy in Nigeria especially in the Southern Provinces (Onitsha, Owerri, Benin and Warri) where leprosy work had been well established and provided a separate allocation of £453,870, in the Development Plan for the first five years, for it. The government created the Nigerian Leprosy Service setting out its mandate as follows:

(1) To supervise and inspect provincial leprosy activities and send reports to the Director of Medical Services.

(2) To investigate and survey new areas and prepare plans for extension.

(3) To train technical staff.

(4) To develop a treatment and preventive service and research.

(5) To carry out these duties through three main institutions (a) provincial leper settlements, (b) leprosy treatment clinics, (c) clan segregation villages.

(6) To establish the following sections within the provincial cente: (a) Home for incurable and helpless lepers, (b) Home for new born uninfected children of leprous parents, (c) Home and school for uninfected children of leprous parents who had no relatives to maintain them.

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40. Annual Report, Warri Province, 1950, p.105.

(7) To co-operate with the Native Administrations and Christian missions that managed the centres before 1945.

On April 1, 1945, the Nigerian Leprosy Service came into existence and took over direct control of Ossiomo, Oji River and Uzuakoli Leper Settlements where leprosy work had been well instituted in the country. In the past, the government only provided grants for capital expenditure at Ossiomo. Under the new system it assumed the following responsibilities: the building of hosptials, treatment of lepers, payment of all workers, segregation of infective lepers, training of lay workers, propaganda, protection of leprous parents, keeping records and maintaining existing records. The new hospital comprised a female ward of eight beds, two male wards of twenty-three beds, and an isolation ward of seven beds. Patients who could not fend for themsevles were first admitted to the hospital for treatment. When discharged, the infected lepers were segregated in the camp to care for themselves as they continued to receive treatment, while non-infective patients continued to receive treatment as out-patients from their homes.[41]

The Area Superintendent, who also was the Medical Officer of the provincial centre took charge of the management and administration of the provincial centre and all activities connected with the control of leprosy in the province, including the supervision of the segregation villages and clinics. He or she developed policy about leprosy control in the province and headed the provincial leprosy board consisting of himself or herself as chairperson and

41. War prof 1, WP 347, p.48: Benin/Warri Leprosy Control Area Annual Report, 1946.

members drawn from the province.[42] All administrative functions including payment of salaries, recruitment of personnel, maintenance services, integration of old workers and negotiation for new segregation villages took off at Ossiomo in 1945. It remained physical development which suffered from a shortage of materials and staff.

The following year some of these problems were eliminated and construction of buildings started. By the end of 1950, some of the most essential buildings, including the treatment block, part of the hospital block, the leprosy officers' house, the water installation, the garage and two senior service quarters had been completed.[43]

In 1948, organised training for layworkers commenced at Ossiomo. Previously, training a layworker involved only placing him or her "in a duty post and leaving him to learn by trial and error and such assistance as his colleagues might find time to give",[44] Such adhoc training did not meet new requirements for a more professional approach, so the Nigerian Leprosy Service introduced a systematic programme of instructions and apprenticeship. Instructions included a minor general medicine course, a minor special medicine course and training in laboratory and sanitary techniques. Trainees acquired practical experience through

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42. *Ibid.*, p.155: Resident Warri to Ast. DO Western Urhobo NA 1-2-49.

43. Annual Report, Development and Welfare Schemes, 1946-1949, p.161; Annual Report, Development and Welfare Schemes 1949-50, p.52.

44. NAI, MH (Fed) 1/1 3987^{G} Enclosure p.252, p.2: Memo, Senior Leprosy Officer Enugu to E. MUIR Sec. BELRA 16/11/46.

attachment to trained workers who assisted them to learn through observation.[45] In subsequent years, the authorities intensified this training programme and produced most sanitary inspectors and nurses who served in the segregation villages. It later became a condition for layworkers to produce a certificate indicating attendance to each course of planned instruction which they attended, the period of apprenticeship and pass in written, oral and practical examination before their appointments could be confirmed.[46]

Ossiomo also adopted the new method of sulphone treatment of leprosy within this period. Sulphone tablets had proved more effective than hydnocarpus oil injection in other parts of the world. Iliffe traces its origin to Dr. Foget, an American physician, who successfully applied sulphone treatment to leprosy in 1941 in the face of widespread scepticism by other experts.[47] Similar experiments had been undertaken by Fromm and Wittman who synthesized sulphone to treat tuberculosis at Freiburg Germany in 1908 and was first used to treat leprosy in India in 1946.[48] The Research Department of the Uzuakoli Leper Settlement confirmed the effectiveness of the new drug after trials on ninety patients in 1946 and recommended it for use in Nigeria.[49] The Nigerian Leprosy Service endorsed

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45. Ibid.

46. Ibid.

47. John Iliffe, *The African Poor: A History* (Cambridge: Cambridge University Press, 1987), pp.225-226.

48. Joseph N. Chuku and Uche M. Ekekezie, *The Leprosy Centre Uzuakoli* (Egbu Owerri: Imo Newspapers, N.D. (1992), p.27.

49. Ibid., p.49, Iliffe, *The African Poor*, pp.225-226.

the recommendation and extended its use to all centres in Nigeria. Patients also preferred sulphone therapy because of its easy administration. Whereas hydnocarpus oil injection was difficult to administer and often resulted in fatal reactions, sulphone tablets were easily administered orally. Sulphone was also cheaper and proved more effective for the treatment of leprosy.[50]

As provided in its mandate, the Nigerian Leprosy Service collaborated with the RCM and the NAs that founded the centre in running it after the take over. The NAs continued to cater for the patients they sponsored through the remittance of their annual quotas to the centre.[51] Their funds also financed the construction of new segregation villages, the improvement of existing villages, the provision of housing for leprosy inspectors, the maintenance of children of infectious mothers and old roads.[52] The RCM continued with their responsibility for all social activities, including operating schools, organising sports, clubs, distributing of alms, re-integrating discharged patients into the community and running homes for unaffected babies and children of leprous patients.[53] The success of the leprosy

50. Annual Report, Warri Province 1950, p.249; Chuku and Ekekezie *Leprosy Centre Uzuakoli* p.26, Iliffe, *The African Poor*, pp.225-226.

51. NAI, War prof 1, WP 437, pp.4, 11, 19-20: Area Superintendent Ossiomo, Quota list for 1944, Area Sup. Ossiomo to Resident Warri, Remittances to Ossiomo 31-3-45; Memo, DMS to Leper Settlements May 1946.

52. NAI, Ughel Dist 1/1422, p.25: Minutes Warri Prov. Leprosy Board 30-8-1950.

53. Ten Year Plan, p.82; NAI, MH (Fed) 1/1/3987^{G}, p.254: Proceedings of Conference Relating to Leprosy at Enugu 23-12-46.

work at Ossiomo in this phase as in the earlier period resulted mainly from this examplary co-operation among the central government, the NAs and the RCM in which each body took responsibility for the functions for which it was most competent.

Clan Segregation Villages

Following a successful experimentation in the Owerri Province in 1935, by the Superintendent of Uzuakoli Leper Settlement, Dr. James Kinnear Brown, the Development Plan endorsed the establishment of village camps in other provinces.[54] They aimed to decentralise the provincial centres. While the Leprosy Service would provide technical assistance, drugs, dressings, staff and transport for regular supervision of the centres from Ossiomo, the communites would donate land, clear the bush, erect a treatment centre and two living quarters. In addition the communities had to construct motorable access roads to the centre and provide good water supply where it was not available.[55] Nurses trained at Ossiomo, who could be lepers or ex-lepers, were to run the centres. With the sub-district leprosy boards, they formulated local policies following directives from the Area Superintendent and the provincial board.[56]

54. Chuku and Ekekezie, *The Leprosy Centre Uzuakoli*, p.21; Iliffe, *The African Poor*, p. 224.

55. NAI, War prof 1, WP 347, p.11: Area Superintendent Ossiomo to Resident Warri on NA Remittances 31-3-45; NAI, Ijaw (W) 4 WI 432 Vol. II p.321: Resident Warri to Sec. Western Provinces 15-6-48.

56. Ibid., p.35: Area Sup. Ossiomo to DO Western Ijaw 16-7-49.

The Area Superintendent of Ossiomo, Dr. Louba Lengauer, opened six segregation villages between 1946 and 1950 in Aboh division at Utagbauno (1946), Ukwage (1947), Aniator (1947), Ibrede (1948), Ossissa (1949), and Igbrudu (1949).[57] Only these communities satisfied the conditions for opening village camps within this period. These segregation villages, like the provincial centre, met popular support, not only with the lepers but also the surrounding communities. Before this time many Delta people had decried the practice of treating lepers in conventional hospitals.[58]

Consequently, the admission of leprosy patients exceeded approved intake in most camps. In 1947 for example, instead of 100 lepers each, Aniator had 155, Ukwage 133, and Utagbauno 127.[59] The clans readily accepted the camps, providing about three and a half acres of land for each of a minimum of 100 patients and building treatment and living quarters for residents.

Many communities were frustrated in their bid to establish camps for their lepers being unable to satisfy all necessary conditions. They included Abraka, Umutu, and Umuguota communities in Aboh division and Okwara, Eku, and

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57. NAI, War prof 1, WP 347, pp.110 & 130: DO Western Ijaw to MO Forcados 4-6-48; Minutes Jekri-Sobo Div. Development Committee 27-7-48.

58. Joseph Okitipkpi, "Lepers in General Hospitals" *Southern Nigerian Defender*, 3 February 1944, p.2; "Health Authorities" *Southern Nigerian Defender* 26 January 1944.]

59. Ten Year Plan, pp. 80-82.

Usoro in the Sobo division.[60] The Usoro community could not construct four and a half miles of road while the Eku community's land for the centre was in dispute.[61] The provision that the NAs should not assist the communities in providing these facilities impeded progress within this period. These conditions compelled the Resident, Warri Province, Richard Leslie Vanghan Wilkes to complain to the regional authorities that:

> No one can quarell with the theory behind the policy but it means that no leper is segregated or treated unless he or his family can pay a substantial sum of money or do a lot of hard work[62]

Some divisional councils questioned the prohibition of their assistance to communities wondering why they should be urged to contribute regularly towards one form of leprosy work and forbidden from spending their money at all on another form.[63] These views, no doubt, influenced re-evaluation of policy later.

The third institution instituted by the Development Plan for the control of leprosy was the clinic. Each leper camp had a clinic attached to it. Separate clinics like the one established earlier at Umutu also existed.[64] They served both

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60. Annual Report, Development and Welfare Schemes 1945-46, p.3.

61. NAI, Ughel Dist 1/1420, pp.12 & 18: DO Urhobo to President Usoro Local Council 16-11-50; SDO Urhobo to Isoko NA 14-8-51.

62. NAI War prof 1, WP 347, p.155: Resident Warri to DO Western Urhobo NA 1-2-49.

63. Ibid.

64. Ibid., Interview, Francis Anho, Aged 80, Retired School Teacher, Abraka, 21 August, 1991.

diagnostic and therapeutic purposes. After diagnosis, infectious patients requiring isolation, were admitted to the camps while non-infective ones continued to receive treatment at the clinic as outpatients.[65] Only the clinics attached to the six villages opened within this period and the separate one at Umutu founded in 1942, operated in the Warri Province within this period. The staffs incharge of the village camps also took charge of the clinics; using the clinic as the outpatients department, except Umutu, where the nurse worked only at the clinic. Like the segregation villages, the clinics came under the regular supervision of the Area Superintendent at Ossiomo.

These clinics attended to a considerable number of out-patients. In 1947, for example, Umutu treated 762 regular patients, Ossiomo 120, Utagbauno 245, Ukwage 274 and Aniator 335. At this stage the communities had come to accept that some cases of leprosy were not contagious and so allowed such relatives to live with them while attending the clinics for treatment.[66]

Smallpox

The Development Plan did not introduce new measures for the control of smallpox and malaria. The provincial authorities in collaboration with the NAs rather extended existing measures to rural communities. In 1948 they launched a mass vaccination campaign in all divisions following serious out-breaks of

65. NAI, Kwale Dist. 1/41 Vol. XVI: Annual Report, Aboh Division, 1946, p.10.

66. NAI, Ijaw (W) 14 (No File No.): Annual Report, Ijaw Division, 1948, p.9.

smallpox in Aboh division where 116 cases were reported.[67] The mass campaign involved house to house inspection in all villages. Before 1948, tours for vaccination remained restricted to towns, government stations and villages close to them while distant villages received attention only during reported out-breaks. The 1948 mass campaign resulted in a large increase in the number of vaccinations of more than 200 percent over the previous years especially in the Urhobo and Kwale divisions as illustrated in Table XXVI below.

Table XXVI

Vaccinations in Various Divisions 1945-1949

Division	Years				
	1945	1946	1947	1948	1949
Aboh	n.a.	5,074	4,560	12,930	n.a.
Western Ijo	n.a.	n.a.	n.a.	8,915	3,486
Urhobo	4,226	5,362	6,156	18,290	24,439

n.a. = not available

Source: NAI, Kwale Dist/41 Vol. XIV^{B}: Annual Report, Aboh Division 1946, p.16; Kwale Dist 1/41Vol. XV: Annual Report, Aboh Division, 1947, p.55; Kwale Dist 1/141 Vol. XVI: Annual Report, Aboh Division, 1948, p.57; Ijaw (W) 14 (No File No.): Annual Report, Ijaw Division, Supplimentary Report, 1949, p.3; Ughel Dist 1/197: Tour for Sanitation and Vaccination, pp.548,606,659,714,789.

67. NAI, Kwale Dist 1/141 vol.XVI: Annual Report, Aboh Division 1946, p.10

The mass vaccination campaigns did not, however, achieve equal success in all the divisions. In Ijo division the difficult terrain and lack of adequate transport hampered tours by the sanitary overseers.[68] The Resident, R.L.V. Wilkes, also noted that the sanitary inspectors in that division "receive(d) little support and cooperation from the people and the councils".[69]

With the mass campaign, the vaccination teams reached some communities for the first time. Consequently, many people showed reluctance similar to their predecessors and for the same reasons discussed earlier. Some attempted to hide smallpox cases. But the educated elite, government workers, chiefs and other more enlightened citizens did not hesitate to report them to the sanitary authorities.[70]

Thus, certain categories of Delta people had assumed a major role in popularising modern medicine and sanitation. They assited medical and sanitary workers in the execution of government policies. By 1950, the size of these groups had increased tremendously. The number of government workers in the province, excluding NA staff, rose from 389 in 1906 to 1113 by the end of 1950, while the number of primary school pupils in the province had risen to 40,000

68. NAI, Ijaw (w) 14 (No. File No.): Annual Report, Ijaw Division, 1948, p.9.

69. NAI, Ijaw (W) 14 (No File No.): Annual Report, Ijaw Division, 1949, p.6; NAI, Ijaw (W) 14 (No File No.): Annual Report, Ijaw Divisioin, 1947, p.7.

70. NAI, Ughel Dist 1/224 pp.427 and 428: J.O. Okoro reporting smallpox cases to DO Urhobo, 10/12/48; Chief Ukieyobo reporting outbreak of smallpox to DO Urhobo 30-11-48.

from about 529 in 1906.[71] Many individuals from these social groups now lived in the rural areas especially with the increasing Nigerianization of the civil service and the new orientation in economic development. As a result of a deliberate policy enunciated by Ormsby Gore discuseed earlier, NA medical and health workers, except medical doctors, were Delta peoples.

Malaria

Malaria control measures did not reach rural communities during this period. They still concentrated at the NA headquarters, towns and some institutions. Even in these stations mosquito control measures had not been adequate. In 1946, the Senior Sanitary Inspector at the Ughelli station, Mr. D.O. Irrechukwu reported that:

> Water tanks in the DO's house and one of the rest houses (Smith's Memorial) are not mosquito proof. Bamboos were not properly cut at the joints, resulting in several stumps with holes, a favourable condition for mosquito breeding. Bamboos used on the tennis court should be so pinned as to leave close ends on the tops.

In the clerk's and messenger's quarters in the Ughelli station, Irrechuku also complained that water held by plants such as plantain, banana, cocoyam and pineapples contained mosquito eggs.[72] By 1949 the situation had not significantly improved as regards mosquito control. At the Ughelli station, Irrechuku still observed that not only were his previous reports not attended to stagnant water

71. Annual Report, Southern Nigeria, 1906 pp.12, 25, 190, 345; Annual Report, Warri Province, 1950, pp.13-15; NAI, CSO 26/2/11857 Vol. XVIII: Annual Report, Warri Province 1941 Onwards (1950), p.3.

72. NAI, Ughel Dist 1/323 Vol. II, p.516: Senior San. Inspector to MO Warri 14-5-46.

was found in other places like the ADO's Rest house and DOs concrete water tank.[73]

Other public health measures like refuse disposal and maintenance of public latrines still remained a problem. Maintenance of these systems were effective only in the government stations, few modern institutions and market places where government labourers carried out these duties. In the Aboh division, for example, labourers carried out these duties only at Obiaruku, Amai, Ogume, Abbi and Ashaka markets, the local government station and dispensaries.[74] Other rural communities relied on their traditional sanitary programmes to keep their public places clean. Suprisingly, some rural communities received positive health reports. In 1946, Irrechuku commended the degree of cleanliness of some village markets maintained by the communities themselves. This vindicted the effectiveness of the co-operation between the government sanitary staff and the traditional sanitary gangs which carried out sanitary duties in the villages following the instructions of the sanitary inspectors. Irrechuku, however, observed and decried indsicriminate defecation in some villages and recommended the introduction of private pit latrines.[75] At the personal levels, the villagers adapted modern sanitation measures

73. NAI, Ughel Dist 1/1075, p.24: Irechuku, Senior San Inspector to MO Warri, 9-12-49.

74. Annual Report, Aboh Division, 1945, pp.11-14; Annual Report, Aboh Division, 1946, pp.10-14.

75. NAI, Ughel Dist 1/323 Vol. II, p.462: Senior San. Inspector Warri to DO Warri 9-1-49.

on their own initiative, depending more or less, on the presence of the educated class within the family circle and the occasional lectures by the sanitary officers.

(d) Native Administration Programmes

The NAs continued to be the main official organ for rural medical services with the assistance of the central government. The Colonial Development and Welfare Scheme introduced a new system of grants-in-aid to support their medical work. It provided an annual subvention of ten percent of each NA's total expenditure on medical and health services. For example, in 1948 when the Urhobo NA spent £1,281 on medical and health services, it received a subvention of £128 for that year.[76] This meant that higher allocations to the health sector would attract higher subventions from the central government. Though the ten-percent subvention did not prove enough incentive for the degree of expansion envisaged by the new Plan it encouraged the NAs to improve the quality of their staff through training and expand dispensary services.

Staff Development

The Development Plan instituted a new polilcy to promote the professionalisation of NA medical and health staff. Unlike in the earlier period when NA medical and health personnel received emergency training in nearby hospitals, Sapele,Warri or Forcados, the new policy emphasised training at accredited government or mission centres such as the Ibadan and Aba schools of hygiene for training sanitary overseers and the Yaba School of Pharmacy for

76. NAI, War prof 1, WP 697, p.53: Ag. DO Urhobo Division to Resident Warri 14-9-49.

training sanitary inspectors and dispensers.[77] Accredited schools of nursing and midwifery included general hospital Akure, Zuma memorial hospital Irrua, RCM hospital Uromi and Saint Philomena's maternity home Benin.[78] These distant centres outside the Warri Province increased the cost of training NA personnel in the province because, in addition to transportation, the NAs had the responsibility for paying salaries and allowances of their employees in training as well as providing lodging, books, equipment and uniforms for them.

Because of these financial burdens, the NAs in the province achieved minimal success in training professionals for their medical and health centres within this period. The Urhobo divisioin recruited and trained only Messrs E.M. Dukafe and J.C. Okujemi as sanitary overseers at the Ibadan School of Hygiene in 1945 and 1949 respectively.[79] The Kwale division recruited three sanitary inspectors posted to Aboh, Ashaka and Ogume in 1945.[80] The Ijo division which had earlier employed three sanitary overseers could neither send them for further training nor recruit a sanitary inspector or more overseers. Nevertherless, the activities of these qualified sanitary officers enhanced the execution of public health measures

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77. NAI, Ijaw (W) 5, 299 Vol. III, pp.361 and 376: DDMS Western Provinces to DMS Lagos 24-10-49; DDMS Western Provinces to Residents 4-7-50.

78. NAI, Kwale Dist 1/813, p.233: Asst. Local Govt. Inspector to Sec. Ukwuani Dist. Council 24-9-56.

79. NAI, Ughel Dist 1/323 Vol. II, p.462: Sen. San. Inspector Warri to DO Warri 9-1-49.

80. NAI, Kwale Dist 1/141 Vol. XIIIB: Annual Report, Aboh Division 1945, p.11.

and resulted in the successes achieved in the mass vaccination campaigns and other disease control meansures discussed earlier. This contrasted with dispensary services where the NAs could not train qualified dispensers within this period. In fact dispensary services did not improve within this period.

3. Extension of Dispensaries

The NAs did not make significant progress in the expansion of dispensaries within this period. Only the Urhobo division built new dispensaries at Oleh, Usoro, Jesse, Udu and Tori before 1950.[81] The Warri division, comprising the Itsekiri section of the Jekri-Sobo division, which became a separate division in 1948, commenced the construction of dispensaries at Ubefan and Ogidigben but could not complete them within this period.[82] The Ijo division only rebuilt the Ramos River dispensary and procured boats for Akugbeme and Ramos River dispensaries to enable the dispensary attendants to visit villages and schools for treatment.[83] The inability of the NAs to effect the desired expansion of dispensaries within this period reflected inadequate funding for expansion. The subvention from the central government did not give them enough encouragement, and revenue acruing from the dispensaries was disappointingly low.

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81. NAI, War prof., WP 74/1, pp.59 and 62: DO Warri to Resident 7-5-52; Ag. DO Urhobo to Resident Warri 29-7-52.

82. NAI, War prof 1, WP 116 Vol. 1, p.75: Public Notice No. 10. 1947; NAI, War prof 2, 235/1 Vol. VIII: Annual Report, Warri Province, 1954 Appendix C, p.14.

83. Annual Report, Ijaw Division, 1948, p.8; Annual Report, Ijaw Division, 1949, p.6.

Despite the clamour for the establishment of more dispensaries by communities, the patterns of the people's acceptance of dispensary services indentified and discussed in chapter three continued in this period. Dispensaries remained most popular in the Ijo division because of the factors already discussed. Even in that division revenue collection in dispensaries dwindled in 1947 and 1948. Available figures for attendances and revenue collected from dispensaries in this division illustrating this trend are shown in Table XXVII. As in the previous period dispensary services continued to be unpopular in other divisions. Available figures on attendances and especially revenue collected from dispensaries in Aboh division tabulated in Table XXVIII below indicate poor patronage to dispensaries in other division. Although attendances increased significantly, trebling those in the years following the introduction of dispensary fees, revenue accruing from them suggests that the dispensaries were mostly attended by persons entitled to free medical treatment. A comparison of attendance figures and revenue collection from Ijo and Aboh divisions (Tables XXVII and XXVIII) brings out the disparity between the appreciation of dispensary services in Ijo and other divisions very clearly.

Table XXVII

Attendance and Revenue Collected in Ijo Dispensaries 1946-1949

Year	Attendance	Revenue collected
1946	11,987	£154:11:11
1947	14,434	£134: 7: 9
1948	10,961	£ 99: 3: 5
1949	12,372	n.a

n.a. = not available

Source: NAI, Ijaw (W) 14 (No file No.): Annual Report, Ijaw Division 1947, p.6; Ijaw (W) 14 (No file No.): Annual Report, Ijaw Division 1948, p.9; Ijaw (W) 14 (No file No.): Annual Report, Ijaw Division, 1949, p.2.

Table XXVIII

Attendance and Revenue Collected in Abbi, Abraka and Utagbauno Dispensaries, Aboh Division 1944-1948

Year	Attendance	Revenue Collected
1944	15,683	£26: -: -
1945	17,688	£26: -: -
1946	28,923	£30: -: -
1947	17,649	£16: -: -
1948	14,974	£14: -: -

Source: NAI, Kwale Dist 1/141 Vol. XIIIB: Annual Report, Aboh Division, 1945, p.11; Kwale Dist 1/141 Vol. XIVB: Annual Report, Aboh Division, 1946, p.9; Kwale Dist. 1/141 Vol. XV: Annual Report, Aboh Division, 1947, p.43; Kwale Dist 1/141 Vol. XVI: Annual Report, Aboh Division, 1948, p.53.

In 1947 and 1948, Bowen explained the fall in attendance in terms of the lack of drugs and dressing throughout the province in those years.[84] This no doubt vitiated the people's initial enthusiasm for dispensary services hence they became reluctant to pay for the services which they might have considered unsatisfactory.

Within this period, the number of people preferring hospital treatment to treatment in dispensaries mainly for the desire to receive medical attention from medical doctors had increased significantly. Even when a medical doctor took charge of a dispensary he still attracted more patients than those managed by dispensers. In 1947, the District Officer of Aboh division, Mr. Noel Eve Whiting, noted that a significant number of people from Aboh division travelled to Eku in Urhobo division to receive treatment from Dr. Canning who ran the American Baptist Mission dispensary at Eku. The fact that the patients from Aboh division ignored the six government-run dispensaries in their division to attend a dispensary in another division indicated that the pull was not just to hospitals, as we noted in chapter three, but to institutions managed by medical doctors no matter their designations. It also suggests a degree of consumer preference. More people had acquired wealth and education and were prepared to pay for better medical attention.

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84. NAI, Kwale Dist 1/141 Vol. XV: Annual Report, Aboh Division, 1947, p.43.

E. Non-Governmental Development

The colonial state continued its policy of partnership with non-governmental agencies and the supervision of their medical work. In this period, it enacted the Private Hospital Ordinance Number 52 of 1945 to regulate the medical activities of non-governmental agencies. The new ordinace re-emphasised the usual practice of registration and regular supervision of their medical work by the Medical Department as described in chapter three.

A. Missionary Medical Work

Initially the Colonial Development and Welfare Scheme did not make provision for a system of grants-in-aid for the medical activities of the Christian missions except for leprosy control. It left the issue of capital grants to the missions at the discretion of the Director of Medical Services or the Chief Commissioners. But in 1947, the government reconsidered the policy and expressed its willingness to give grants for equipment, training of staff, and buildings to approved mission medical institutions which served the general public.[85] This new policy resulted in a grant of £750 to the Eku Baptist Mission Hospital in 1949 for the purchase of an ambullance.[86] No other mission received any other grant direct from the Development Fund during this period. Therefore

85. S. Phillipson, Report on Grants-in-aid on Medical and Health Services provided by Voluntary Agencies in Nigeria (Lagos: Govt. Printer, 1949), p.21.

86. NAI, Ughel Dist. 1/289, pp.45 and 46: SDO Urhobo Division to Dr. Canning Eku Hospital, 16-9-49, Dr. Canning to SDO Urhobo Division 22-9-49.

the following medical activities of the Christian Missions were not inspired by the Colonial Development and Welfare Scheme but rather, were a continuation of their medical work to the rural communities which commenced in 1930 in the Warri Province.

We recall that by the end of 1944, the CMS had opened maternity homes at Ole, Igbudu, Ughelli and Umuoru as well as a dispensary at Oleh.[87] It secured registration for these institutions under the new ordinance.[88] Due to financial constraints the CMS could not undertake large scale expansion within this period. Its headquarter, Iyienu, could not balance its accounts in 1945 and therefore could not finance further expansion. In that year, the hosptial authorities complained that:

> Owing to the increased cost of living necessitating higher wages, and the increase in maintenance and equipment, the hospital has a large deficit in 1945. The Native Administrations have given us some financial assistance. No assistance has been received from the Government. We regret the recent statement of the Governor on the Policy with regard to the relationship between the Government and the Mission activities (October 6th) that "only at a later stage, in exceptional and selected cases Government may consider modest capital grants to Missions".[89]

An attempt by the Sister Supervisor of CMS Niger Mission Maternity Service in the Warri Province, Miss Dorothy Jewitt, to secure a loan from the Urhobo NA to

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87. NAI, MH (Fed) 1/1/5384F: Annual Medical Report, Nigeria, 1944, p.8[A].

88. NAI, War prof 1, WP 206/4, p.16. DO Aboh to Resident Warri Province 1-10-47.

89. NAI MH(Fed) 1/1/6038[F], Annual Medical and Sanitary Report, Nigeria, 1945-46, p.71.

reconstruct the Ughelli and Oleh maternity homes in 1948 failed.[90] The Resident, Bowen, turned down the application on the grounds that it was unprecedented and could prompt similar requests from other missions and that he would also require the approval of his excellency.[91] The assistance never came. The CMS, however, raised funds from local churches to reconstruct the Ughelli maternity home. It further opened a new one at Abbi and a dispensary at Umuoru.[92]

The Roman Catholic and the American Baptist Missions also initiated maternity and dispensary services in the province within this period. The Roman Catholic's Our Lady of Lourdes maternity home Obiaruku and the Saint Elizabeth maternity home Sapele got registered in 1945.[93] The Baptist Mission's dispensary and welfare centre was opened in 1945 by a missionary nurse, Mrs. E.M. Howell, wife of Rev. Howell the Baptist missionary at Eku. In 1947, Dr. Harold Canning joined the staff of the dispensary and boosted its services. In 1949, Mary Evelyn Fredenburg joined the staff to develop a nursing service. She took over the running of the clinic while Dr. Canning devoted more attention to building a hospital there. The thirty-two bed hospital eventually opened on July 1950 with

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90. NAI War prof 1 WP 206/4 p.26: D. Jewitt, Sister Supervisor CMS Health Institution to DO Ughelli 7-6-48.

91. NAI, War prof 1, WP 206/1, p.4: Bowen, S DO Warri to DO Ughelli 3-12-43; NAI, War Prof 1. WP 206/4, p.2; Resident Warri to DO Kwale 24-2-47.

92. NAI, MH (Fed) 1/1/7359^{F}: Annual Medical Report, Nigeria, 1947, p.5^{E}.

93. NAI, MH (Fed) 1/1/6662^{F}: Annual Medical Report, Nigeria, 1946, p.41$^{A\&B}$.

Dr. William Gaventa as the medical supervisor, after Dr. Danning had left the country.

The Eku community enthusiastically accepted modern medical institutions and willingly supplied communal labour to build the dispensary and welfare centre. The sponteneous positive reaction to the demands of the mission for th project provides insight into the expansion of christianity and the quest for modern medical services. A son of the town, Rev. Jove Egovi Aganbi, of the Baptist Church helped secure land, organise community labour and local contributions towards the project. The Eku people contributed ten shillings each to compensate their members whose economic trees were to be destroyed when it became necessary to expand the original site later. Initially the community provided a twenty acre rubber plantation as site for the mission station and the hospital. The Church elders vividly recall that on the day scheduled for building to start that:

> When the Missionaries arrived, they were amazed to discover that all the rubber trees had been cut down, roots dug up and all taken away. The whole village, christians and non christians, adults and children had worked all night. They sang, "we do not want any money for the land or the trees. We want the Missionaries to live in our land".

During the opening ceremony of the hospital in 1950 everyone participated in the festivities. In the words of the Church chroniclers:

> The crowd was huge as missionaries, African Chiefs, British government officials, Europeans, pastors and multitudes of Nigerians came to witness the opening of the hospital, a dream finally realised after decades of prayer and anticipation. The speakers expressed great hope for the hospital as a means of ministering to the body and soul of man in the Lord's Name.[94]

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94. Ibid., Annual Report, Warri Province, 1941 Onwards (1950), p.41; "History of Eku Baptist Hospital, paper presented at its 40th Anniversary by the Organising Committee 1990", pp.1-2.

The memory of Rev. Aganbi as a champion of the course of Christianity in Urhoboland and especially the development of modern medicine at Eku has ever remained fresh in the minds of his people. Recently, the Eku community named a secondary school after him to immortalise his name. Likewise the mutual love and friendliness that developed between the Urhobo people and Dr. Canning, who supervised the building of the hospital facilitated co-operation between the community and the mission. In 1950, the elders of Eku town honoured him with a traditional Urhobo marriage ceremony when he married. Though in the USA when the hospital opened, Canning sent a congratulatory message from there to the Eku people as well as to prominent traditional rulers in Urhoboland.[95]

Community Development

Other communities initiated the construction of maternity homes and dispensaries. The Abraka community under the leadership of Chief Jessa Ogboru built a maternity home, the Immaculate Conception, at Oria Abraka in 1946. The community initially proposed to entrust the supervision of the centre to the doctor at Eku but eventually handed it over to the RCM to manage. The funfare that marked the opening of the Eku hospital also featured at the opening ceremony of the community maternity home.[96] Applications by other communities to establish modern medical institutions were not successful because they failed to meet all necessary conditions for such establishments. For example, the application of the Oginigbo community to open a community sponsored dispensary failed because of

95. "Eku Baptist Hospital Opened" *The Nigerian Standard* 27 July 1950, pp.1, 3 and 8.

96. NAI, War prof 1, WP 206/4, p.9: Chief Ogboru to Resident Warri 21-4-47.

the nearness of their site to an existing NA dispensary and a proposed NA dispensary at Ovbakwa. The Medical Department stipulated that similar institutions should not be established within a radius of ten miles.[97] Thus, the Delta communities demonstrated their willingness to supplement government medical activities if authorised to do so.

B. Commercial Companies' Medical Work

Various commercial companies operating within Warri Province also contributed to the expansion of modern medical services by providing medical treatment for their workers and their families. Like the Christian Mission their work received no direct financial aid from the Colonial Development and Welfare Plan. These companies' industrial areas had earlier been recognised as Labour Health Areas which received regular inspection from the public health officers.

These companies opened several new medical facilities for their staff within this period. The Palmol Company Sapele opened a maternity at Sapele Rubber Estate in 1946, a dispensary in the same Estate in 1947, a hospital and a maternity home at the Cowan Estate Ajagbodudu in 1949, and extended dispensary services to Ologbo in 1950.[98] Similarly, the Nigerian Hardwood Company opened dispensaries at Kwale and Tolele near Obiaruku in 1949,[99] while the African

97. NAI, Ughel Dist 1/1550, pp.126 and 129; SDO Ughelli to Dr. Gaventa Eku Hospital 6-5-52; MO Sapele to SDO Ughelli 7-4-52.

98. NAI, MH/Fed/1/1/9128[L]: Annual Medical Report, Nigeria, 1949, Private Medical Activities, p.9.

99. Ibid.

Timber and Plywood Company Sapele opened a dispensary there in 1950.

The companies had become aware that the provision of modern medical services represented an important factor in the development of a reliable labour force because high manpower productivity depended on a healthy labour force. As the companies concentrated in Sapele and its environs the provision of adequate social services also enhanced the chances of attracting the required labour force, which at the time was very scarce. So, even though the companies had mostly men as their workers they considered it very expedient to provide maternal care services for their workers' wives and medical care for their other relatives to minimise the rate of absentism due to family health problems. The policy also facilitated the reproduction of the labour force.[100] Company medical services which they also extended to non-company workers, who paid for their treatment, helped to popularise the efficacy of modern medicine and its acceptance. The fact that inadequate health facilities did not feature in the various industrial disputes between the workers and their companies suggests that the employees received fairly satisfactory medical attention from their various companies.[101]

C. Patent Medicine

By 1945, the patent medicine business had become very popular and lucrative in Warri Province, as in other provinces. Popular preference for purchasing drugs from medicine stores derived from a widespread knowledge of

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100. Interview, Daniel Adam Obagbinoko, Aged 80, Retired Company Dispenser and Private Chemist, Ovu 25-4-95.

101. Annual Report, Western Provinces of Nigeria, 1946 p.22; "Strikes" *Nigerian Star*, 22 May 1950, p.1.

the effectiveness of modern medicine in treating common disease such as headache, fever, stomach pains and disorders, skin diseases, malaria and yaws. Many had learned basic treatment for common ailments through hygiene and domestic science courses. Throughout the period newspapers also carried advertisements on a large number of drugs. In January 1930 alone, the Daily Times carried advertisement on fifteen different drugs elaborating on their therapeutic functions, repeating some advertisements several times within the month as shown on Table XXIX below.

Table XXIX

Advertisements of Drugs in Daily Times January 1-31, 1930

	Drugs	Dates of Advertisement With pages in Brackets	Diseases Cured
1.	Krushen Salt	2(5), 17(7), 21(7), 23(7), 30(6)	Indigestion
2.	Vertazo	4(2)	Blood medicine
3.	Peps Syrup	4(3)	Cough, Cold, Bronchitis Chest pain.
4.	Bisurated Magnesia	4(7), 18(16)	Digestive pain
5.	Wincaris Syrup	4(9), 11(5), 18(7), 25(9)	Building body and nerves
6.	Mentholatum	6(7), 11(4), 13(6), 20(7), 27(6)	Sore, Itching, Skin diseases
7.	Sloans (NB) Liniment	7(3), 21(6), 30(2)	Pains, Rheumatism, Lumbago, Sprains, Bruises
8.	Dewitts Kidney and Bladder Pills	7(7), 14(6), 21(6), 29(5)	Sciatica, lumbago, chronic back ache.
9.	At-woods Bitter Mixture.	10(6), 25(8)	Weakness, Fever, Headache, Indigestion
10.	Zambuk balm	11(7), 25(7)	Skin diseases, cuts, sores
11.	Pan-Yan pickle	4(6)	Sores and cuts
12.	Sanatogen	17(5)	Constant fatigue
13.	Steedmans Powder	20(6), 29(5)	Constipation (babies)
14.	Yaro Mixture	23(5)	Fever, Measles, Fits
15.	Insect bite stick	25(6)	Mosquito (Malaria)

Source: Daily Times, January 1-31, 1930. Dates and pages are as in column 2.

Besides, medicine dealers advertised the stocks of medicine in their stores. For example, on 11 January 1930, the St. Thomas Dealers in Patent and Proprietary Medicine advertised their stock in the Daily Times thus:

> Our large stock includes Eno's Fruit Salt, Krushen's, Beecham's, Holloway's, Dewitt's, Doan's and Morse's Pills, Pageol, Archeol, Catholicos, Bell tongue. Syrups, all well known cough mixtures, Verno's, Owbridge's, Galloway's etc. Borgoyn's Burbidges' special preparations, Broom a site, Normo gastrine, Ixidama, Netramyne etc. Burrough's, Welcomes Tabloids, Asprine, Quinine, Didymin etc. Olive, Castor oil and codliver oils. Peps for cough.[102]

The publicity given to drugs and their curative and preventive potency by manufacturers and dealers which gained greater momentum in subsequent years popularised patent medicine practice by sharpening the peoples awareness of the use of existing drugs.

Many more people gained the knowledge of the potency of drugs through hospital admissions or mere treatment in hosptials and dispensaries. In government hospitals there was the practice of displaying patients' cards, "on the wall of the wards with the diagnosis and treatment written on the front page for any one, everyone to see".[103] Through this practice literate patients or their relatives identified effective drugs and recommended such drugs for anybody having such a malady.

The personal knowledge and use of modern drugs happened to coincide

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102. St. Thomas Dealers in Patent and Proprietary Medicine "Advertisement". *Daily Times*, 11 January 1930, p.9.

103. Adeloye, *African Pioneers of Modern Medicine*, p.66.

with the traditional practice of using common herbs for home remedies as discussed in chapter one. Families could easily collect known herbs and treat such common ailments as headache, cuts, fever and malaria without consulting a traditional medicine man. Likewise, with the knowledge of the use of some modern drugs patients preferred buying drugs from any nearby medicine store or hawker to treat himself or members of his family. Some modes of treatment in the two systems such as taking liquid potions orally and rubbing liniments on affected parts of the body were similar and thereby made it easy for the people to adopt the use of modern drugs.

This practice of self medication made patent medicine stores and dealers more popular among the Delta peoples than dispensaries and even hospitals for treating simple ailments because they possessed several other advantages over these institutions. Availability of drugs in the medicine stores endeared them to people seeking urgent treatment for minor injuries or illness. Often, hospitals and dispensaries sent their patients to buy prescribed drugs from the medicine stores when they lacked drugs. Therefore, people saw nothing wrong with going, on their own, to purchase drugs known to be effective for certain ailments. They also sought medical advice from the patent medicine dealers in some cases. Nearness of the medicine stores to the sick proved a bonus to people who would have travelled long distances to the lone dispensary in the clan or hospital in the division. Moreover, patent medicine dealers established an intimacy with their clients leading to credit facilities which conventional government institutions would not grant. In addition, their services were quicker and cheaper than those of government institutions. They never required the registration of patients or the

issue of cards to them. These constituted regular protocols in the dispensaries or hospitals which invariably added to the cost of running the institutions. The drugs had to cover these costs, hence treatment charges in the government institutions were higher. These advantages really attracted most people to medicine stores. Daniel Adam Obagbinoko, a retired company dispenser and a patent medicine dealer, explained:

> In my chemist, I received patients day and night. There were so many patients that we kept awake most part of the night to attend to them. But in the dispensaries it was not like that. We could have 30-50 patients a day.[104]

He had gained experience in a company dispensary where workers and their family members enjoyed free medical treatment. In the NA and government dispensaries the attendance rarely exceeded ten daily for fee paying patients.[105]

The preference for treament in the medicine stores or by medicine hawkers, unfortunately resulted in patients patronising unqualified medical practitioners who administered illegal injections and other drugs which did some harm to their clients. Because of the danger posed by the activities of these unqualified providers of modern medicine the colonial government stepped in to regulate their activities. It enacted the Pharmacy Ordinance of 1945. The ordinance emphasised the issue of lincences to importers and distributors of modern medicine as well as

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104. Interview, Obagbinoko.

105. Interviews, Obagbinoko; Gabriel Ejedegha, Aged 48, Serving Pharmacy Technician, Abraka, 24-4-95.

to medicine vendors by introducing a register for them.[106] The ordinance came into effect on March 1, 1946 by Order-in-Council number 2 of 1946. The residents granted the licences which were also renewable annually with a fee of five shillings.[107]

In the Warri Province, as in the other provinces, the licencing system received a spontaneous response from people engaged in the medicine business. Between March 1, 1946 when the ordinance came into effect and May 1946, when it was suspended, twenty three importation and distribution of drugs licences and thirty-three vendor's licences were issued in the Warri Province amidst numerous applications.[108] The rush for licences affirmed the popularity of patent medicine business because of the great demand for English drugs.

The government suspended the issue of licences after two months because several problems arose from its administration. The Chief Commissioner of the Western Provinces, Theo Hoskyns Abrahall, observed that:

> There are innumerable market women and itinerant vendors selling small quantities of the common brands of medicines and to attempt to enforce a licencing system against such persons would require a special staff and inspection.[109]

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106. NAI War prof 1, WP 370 p.90: Medical School Yaba to Resident Warri 18-12-46,

107. *Ibid.*, p.88: Resident Warri to Sister Supervisor CMS 26-7-46.

108. *Ibid*; pp.104 and 203: Resident Warri to Medical School Yaba 11-2-47, Resident Warri to H.E. Muyen (Applicant) 12-7-51.

109. *Ibid.*, p.78: H.F. Marshall CSG to DMS 16-6-46.

The government also felt that the residents were not the suitable authority for issuing these licences in view of the enormous work facing them.[110] Consequently, the government appointed a superintendent pharmacist for each region, in 1948, to inspect shops and stalls of patent medicine.[111] In 1951, the government removed the responsibility of processing applications for the importation and distribution of antibiotics or dangerous drugs from the residents and vested it on the senior medical storekeeper Lagos.[112] Another problem emanated from the appropriate designation for the patent medicine licences. The question arose whether the licences should be issued for all premises where patent and proprietary medicine were sold or to persons selling the drugs. The Chief Secretary of the Western Provinces, H.F. Marshall, directed that:

> It is the person and not the place of business which requires to be licenced. The proprietor of more than one shop need therefore take out only one licence (and that) every vendor of patent and proprietary medicine must take out a licence.[113]

The government could not resolve the question of the appropriate authority to issue patent medicine licences in the provinces before the end of the period covered by this chapter. So, the ban remained till 1954. Inspite of the ban all licenced patent medicine dealers continued to operate without renewal while the

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110. *Ibid.*, p.76: Ag. Sec. Western Region to Resident Warri 18-5-46.

111. *Ibid.*, p.216: LA Burutu to Resident Warri 15-8-51.

112. *Ibid.*, p.224: Circular from DMS to Residents 18-8-51.

113. *Ibid.*, p.76: Ag. Sec. Western Region to Resident Warri 18-5-46.

unlicenced ones continued to operate without licences. The danger posed by their activities, notwithstanding, they brought modern medicine to the remotest areas in the Warri province within this period. For instance, in Burutu alone, twenty-one medicine stores had been opened before August 1951.[114]

Assessment of Policy and Implementation

To assess progress made during the first five years of the Ten-Year Development Plan, we examine the extent to which the different arms of government executed projects and programmes in the plan and the quality of services rendered within this period. Only in two of the projects they directly executed did the federal authorities achieve the desired goals to a large extent. The Nigerian Leprosy Service completed all the responsibilities assigned to it at Ossiomo including physical development. This justified the official view that by 1950 the work of the Leprosy Service had been consolidated in the Benin and Warri Provinces.[115] They also sank a reasonable number of wells under the rural water supply scheme: seventy per cent in Ijo division and eighty-five per cent in the Urhobo division, for example.[116] Nevertheless, this success was vitiated by the unsatisfactory functioning of most wells.[117]

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114. *Ibid.*, p.216: LA Burutu to Resident Warri 15-8-51.

115. Annual Report, Development and Welfare Schemes 1950-51, p.50.

116. NAI, War prof 1, WP1200, p.39: Minutes of Urhobo Divisional Council 3-2-46; Annual Report, Development and Welfare Schemes 1946-1949, p.8; NAI, Ughel. Dist 1/1264/1: Annual Report, Development and Welfare Scheme 1950-51, p.9; NAI, Ijaw (W) WI 335 Vol. I: Annual Report, Ijaw Division, 1949, p.238.

117. Annual Report, Development and Welfare Scheme 1950-51, p.9.

The federal authorities achieved only partial success in the execution of urban water projects and the establishment of clan leper segregation camps. Though work started at the Warri urban water scheme, the only one in the province, on schedule (1946), it was not completed within this period as proposed. Only one division established six leper segregation camps while all the applications from other divisions were frustrated because they could not satisfy some stringent conditions which infact impeded the establishment of village camps in all the divisions except Aboh.[118]

All other projects under the federal authorities received little or no attention within this period. Work only started lately (1950), at the Warri hosptial extension project whereas nothing was done at the other hospital extension projects as well as the new hospital projects. Failure to execute physical development projects by the federal authorities resulted from difficulties in obtaining adequate staff and materials. We have shown the position of staffing and supply of materials earlier in our discussion on the water supply projects. The situation was worse in other areas hence work did not take off at all. In 1949, the Medical Department acknowledged the poor performance of the Plan and confessed that it was "due mainly to the persistently shortage of personnel both in the Medical Department and the Public Works Department."[119]

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118. NAI, War prof 1, WP 347, pp.156-157: Resident Warri to Sec. Western Provinces 20-2-49.

119. Annual Report, Development and Welfare Scheme 1950-51, p.9.

One can also suggest that vesting the execution of most projects on the federal authorities resulted in the little achievements made within this period. It took much time for the funds, materials and staff to reach the regional, provincial and divisional headquarters, in that order, before distribution to the various locations where they were needed. We noted earlier that most materials arrived in Nigeria from Britain in 1950 and before the distribution process could be completed, the first phase of the implementation of the Plan had ended.

The provincial authorities only extended conservancy services to private individuals and companies in Warri and Sapele. In the absence of a better system of disposing human excrement these town dwellers welcomed the pail system inspite of its deficiencies.

The NAs recorded limited successes in the resposibilities invested on them. Except for the mass vaccination campaigns, carried out successfully in most divisions, they achieved very little in other schemes. They recruited or trained few sanitary inspectors, overseers and labourers. Because of that, other public health measures did not extend to the rural communities due to shortage of staff. No division trained any professional dispenser, dispensary attendant or midwife as required by the new plan. Only the Urhobo division and the Itsekiri division, carved out from the former Jekri-Sobo division, undertook the establishment of new dispensaries. But the Itsekiri division could not complete constructing the dispensaries within this period. No division undertook the establishment of

maternity homes, except that the Aboh division employed a domiciliary midwife at Ashaka in 1948.[120]

It appears that the ten-percent subventions of each NA's annual expenditure, which the Colonial Department funds provided did not give them enough financial support to shoulder the responsibilities assigned to them in the Plan. The ADO, Itsekiri NA had cause to complain that:

> The 10% grants has only helped the richer Native Administrations who could afford the necessary balance of 90% of the expenditure and had little or no impact on the poor ones.[121]

As a result of inadequate finances the NAs could no longer maintain the dispensaries they established earlier. Lack of drugs and inadequate staffing persisted throughout this period.[122] Owing to shortage of staff, dispensary attendants in Aboh NA did not go on annual leave in 1947 because there were no spare attendants to relieve them.[123] In the same year, the Ijo division loaned a dispensary attendant from the Kwale NA, while the Oloibiri dispensary closed down, in 1948, because there was no dispensary attendant.[124]

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120. NAI, Kwale Dist 1/813, p.3: Ag. DO Aboh Div. to MO Sapele 7-5-49.

121. NAI, War prof 1, WP 697, p.51: Ag DO Warri Div. to Resident Warri, 6-9-49.

122. Annual Report, Aboh Division, 1947, p.43.

123. Ibid., p.44.

124. Annual Report, Ijaw Division, 1947, p.6; Annual Report, Ijaw Division, 1949 (Supplementary Report), p.2.

Consequently, the teeming population of Delta peoples who had become inclined to modern medical and health services through Western education and enlightenment campaigns remained disappointed because their demands could not be met. The disappointment resulted in resort to self treatment and patronising all private providers of modern medicine including quacks. But more importantly communities initiated the establishment of their own medical institutions to supplement government services.

Policy makers realised their failure to achieve the objectives enunciated in the Colonial Development and Welfare Scheme for the first five years. Consequently, they decided to revise the entire plan at the end of the first phase, instead of a mere review proposed initially. The extent to which the colonial administration rectified the above identified short-comings in the original scheme, during the second phase, will be the object of our next chapter.

CHAPTER FIVE

RAPID EXPANSION OF MODERN HEALTH FACILITIES IN THE DECOLONISATION PERIOD 1951-1960

A. Revision of Policy and Implementation Strategy

By 1948, the colonial government had become aware of major problems in the implementation of the Development Plan hence its timely decision to overhaul the entire Plan at the end of the first phase instead of a review proposed initially. It gave the following reasons for its decision:

(1) The available funds could no longer cover the capital cost of the original plan due to general rise in costs;

(2) There was need to incorporate new ideas and projects which should be provided for, even if it meant excluding some earlier ones;

(3) To satisfy the criticism that, "The Ten Year Plan had not taken sufficiently into account Nigerian opinion", in view of the emergence of Federal and Regional Legislative Councils following the introduction of the 1946 constitution.[1]

For more effective planning and implementation of programmes in the new plan the federal authorities mandated the regions to initiate proposals for projects and programmes in their areas of authority with the following terms of reference:

1. *A Revised Plan of Development and Welfare Nigeria 1951-56, Sessional Paper No. 6 of 1951* (Lagos: Government Printer, 1951), pp.3-5

(1) To make recommendations regarding any re-orientation of the plan which may be considered necessary either by way of bringing in new schemes and possibly scrapping or differing others which at present have place in it, or by modifying existing ones.

(2) Ensuring that proper proportions are maintained between economic development and the development of social services.

The regions were also to implement the new policy with a freehand to adjust the plan giving preference to projects which "commended the highest priority" and ensuring that the greatest number of people benefitted from the programmes.[2] The regions made their proposals within the limits of the following allocations from the federal government based on a quota of fifty percent to the North and twenty-five percent each to the West and East. Table XXX below shows the initial allocations and the approved sums for regional projects.

Table XXX

Regional Allocations in the Revised Plan

Region	Initial Allocation	Regional Proposal	Approved Sums
North	12,900,000.00	13,692,463.00	12,648,741.00
East	5,340,000.00	5,888,018.00	5,494,167.00
West	5,885,000.00	7,223,654.00	5,882,323.00
Central	0	0	10,158,410.00

Source: A Revised Plan of Development and Welfare for Nigeria 1951-56 (Lagos: Government Printer, 1951), pp.6 and 9.

2. Ibid., pp.5-9.

To elicit sufficient public opinion, the regional authorities involved all the provincial and local authorities by calling for their views on the various projects covered by the original plan as it affected them. This gave the public the opportunity to channel their views through their local and divisional councils as well as the provincial board members whose suggestions were communicated through the District Officers and the Residents to the regional authorities. Some suggestions which eventually affected policy originated from the Warri Province. The Resident, R.A. Vosper, made a strong case for launch transport for the riverine areas of Aboh, Western Ijaw and Warri divisions, maintaining that the future economic, political and social development of these areas depended on the provision of a reasonably rapid and cheap transport. According to him, this was the only way to keep the more intelligent youths at home.[3] He decried the policy which prohibited any form of financial assistance from the governments to clans establishing leper segregation camps. Thus, he echoed the view of most divisional councils which preferred to finance the establishment of their own clan camps to contributing regularly to Ossiomo. He also echoed the view of the District Officer of Itsekiri that the ten per cent subvention to the NAs for their health services did not encourage meaningful development.[4] These views influenced the formulation of the Revised Plan as we shall elaborate while discussing the various programmes.

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3. *Ibid.*

4. NAI, War prof, WP 697p.5l: Ag. DO Warri to Resident Warri 6-9-49.

Regionalisation of some government departments, including the medical department, following the introduction of the 1951 constitution further devolved power to the regions enabling them to introduce regional policies. The Western regional government introduced its health policy in 1952 to complement the Revised Plan. Among other programmes it introduced free school medical services.[5] The successful implementation of the two policies resulted in a very rapid expansion of medical facilities within this period.

There were still issues and programmes for which the federal government formulated national policies which it implemented directly. To elicit public opinion it constituted several commissions to conduct detailed enquiries on such issues and make recommendations. For example, by June 1948, it inaugurated the Sir Sydney Phillipsons' Commission to make recommendations on the nature of grants-in-aid to be introduced to support the health services of voluntary agencies.[6] In April 1949, it constituted another Phillipson's Commission to study and make recommendations on the private practice of medicine and surgery by officers of

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5. Public Health Policy for the Western Region, Nigeria (Ibadan: Government Printer, 1952), pp.1-7.

6. S. Phllipson, *Report on Grants-in-aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria* (Lagos: Government Printer, 1949), p.1.

the department of medical services.[7] These reports which will be discussed in the relevant sections in this chapter influenced government policy in the Revised Plan distinguishing it from the original plan.

The Revised Plan, details of which are shown in Table XXXI below, incorporated most projects of the original plan, added a few new ones and removed some. For health services the objectives and schemes in the original plan: provision of new hospitals and the extension of existing ones; establishment of Rural Health Centres, Medical Field Units, Maternity and Child welfare Centres; training medical personnel and leprosy control were retained. In addition it introduced grants for voluntary agency hospitals and hospitals jointly established by government and voluntary agencies. The degree of extension of most hospitals was, however, reduced while policy procedures that did not work well in the original play changed. Details of changes of policy and procudure will be discussed under the various schemes affected.

Though the Revised Plan was meant to cover the period from 1951 to 1956 it extended to 1960 for the implementation of medical and health services because the New Five Year Plan of the federal government covering the period 1955 to 1960 did not introduce new schemes for most social services. The new plan favoured economic development, describing its period (1955 to 1960) as one

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7. Statement of the conclusions of the Government on the Report of the Commission on the Private Practice of Medicine and Surgery by Officers of the Department of Medical Services, Nigeria (Lagos: Government Printer, 1949), p.1.

Table XXXI
The Original Plan and the Revised Plan Compared

Schemes and Projects	Ten Year Plan Amount Provided	Revised Plan (5 Years) Amount Provided
A. Social Services and Administration	**£**	**£**
Development Officers	895,500.00	484,200.00
General Education	6,032,340.00	2,955,380.00
Medical and Health	10,438,837.00	5,849,356.00
Gaskiya Corporation	152,350.00	0.00
Social Welfare	384,000.00	329,146.00
Statistics	100,000.00	720,000.00
Total	18,824,027.00	10,338,082.00
	38%	30.30%
B Basic Equipment		
Water Supplies	8,062,000.00	4,644,204.00
Roads	7,046,300.00	3,177,004.00
Electricity	1,544,200.00	500,000.00
Telecommunications	820,000.00	1,233,850.00
Marine	3,517,940.00	14,956,000.00
Technical Education	1,115,453.00	3,932,547.00
Community Development	332,000.00	485,500.00
Rural Training Centre	0.00	69,720.00
Total	22,437,893.00	15,537,931.00
	45.30%	45.40%
C Productive Services and Revenue Earning Projects Remainder of Plan	8,206,346.00	8,307,638.00
	16.70%	24.30%

Source: A Revised Plan of Development and Welfare for Nigeria 1951-1956 (Lagos: Government Printer, 1951) p.4

of consolidation rather than further expansion for the social services.[8] This chapter aims to discuss health policy of the Revised Plan, its implementation and impact on the expansion of modern medical and health services in the Warri/Delta Province.

B. Implementation of Medical and Health Schemes in the Warri/Delta Province

The Revised Plan affirmed the following projects and objectives in the original plan for the province though with some modifications: hospital and health centre projects, medical field unit for the control of epidemic and endemic diseases in the urban and rural areas, urban and rural water schemes, public health services, staff development and encouraging non-governmental agencies. We now discuss the new policies and their implementation in details.

(1) Hospital and Health Centre Projects

The Revised Plan retained all the hospital and health centre projects for the province in the original plan except for the extension of the Forcados hospital which it dropped. It also curtailed the degree of extension originally planned for the other existing hospitals. It reduced the extension of Warri General Hospital from one hundred and seventy six to sixty-six beds and Sapele General Hospital

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8. NAI, Ughel District 1/1727, p.1: Policy paper from Civil Secretary's Office, Ibadan to Permanent Secretaries 25-11-53.

from sixty to fifty beds. The proposed new sixty bed General Hospital for Kwale and a Rural Health Centre for Ughelli remained as earlier planned. The extension exercise in Sapele and Warri hospitals recognised the growing need for maternity work. Twenty out of the fifty beds increase at Sapele were for maternity services. This was the first time of introducing maternity beds to the hospital. Likewise, twenty out of the sixty-six beds increase in the Warri General Hospital were for maternity services while sixteen beds were for a Tuberculosis Pavillion introduced for the first time to replace the originally projected large regional sanatoria.

The Revised Plan also proposed a Launch and Motor Barge Ambulance Dispensary to be based at Forcados from where it would tour the riverain areas of Forcados, Warri and Sapele. This new provision replaced the extension of Forcados General Hospital provided for in the original plan.[9] The Plan provided funds for the execution of these projects between 1951 and 1956 as shown in Table XXXII below.

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9. NAI, Sap. Dist/1/1/171 Vol. 1, p.119: Nigerian Secretariat Lagos to Sec. Western Provinces 12-7-50 on Revision of Ten-Year Dev. Plan.

Table XXXII

Hospital and Health Centre Projects Delta Province Estimate 1951-956

Project	Year of Execution	Capital Cost £	Recurrent	Total £
Warri Hospital Extension	1950-1951	13,640.00	19,940.00	33,580.00
Sapele Hospital Extension	1952-1955	16,730.00	24,400.00	42,130.00
Ughelli Rural Health Centre (New)	1953-54	8,190.00	10,150.00	18,340.00
Kwale General Hospital (New)	1954-55	28,830.00	12,000.00	40,030.00
Benin/Warri Medical Field Unit	1954-55	3,960.00	14,695.00	18,635.00
Forcados Launch		3,000.00		3,000.00
Motor Barge Ambulance Dispensary		7,000.00		7,000.00

Source: A Revised Plan of Development and welfare for Nigeria 1951-1956 (Lagos: Government Printer, 1951) pp.86-88; Sap. Dist 1/1/171 vol: 1, Development Papers pp.114-119.

Execution of these projects commenced on schedule for some schemes but delayed in others. Work at the extension of the Warri hospital resumed in 1950 and was completed in 1952.[10] Two years later work at the Sapele hosptial started, ending in 1955. In addition, the government transferred the Infectious Disease Hosptial to a new site having designated the old site for residential houses.[11]

Work on the new institutions which aimed to extend medical treatment to the rural areas as well as to the inaccessible riverain areas also started on schedule. The Launch and the Floating Dispensary meant to serve the creek areas of Forcados, Sapele and Warri, with their base at Forcados was commissioned in 1953.[12] The Rural Health Centre Ughelli opened in February 1955, whereas the foundation stone for the Kwale General Hospital was laid on 20 September 1954 and completed in 1956.[13]

With the completion of these projects the colonial government had made a

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10. Annual Reports, Development and Welfare Scheme 1951/52, p.44; 1952/53, p.52.

11. NAI, War prof 2, 235/1 Vol. VIII: Annual Report, Delta Province, 1954 Enclosure p.7, p.9; MH/Fed/1/1/12616^{C}. Annual Medical Report, Western Region, 1954, p.3.

12. NAI, War prof. 2,235/1 Vol. VII: Annual Report, Delta Province, 1953, Enclosure p.77, p.18.

13. NAI, War prof 2, 235/1 Vol. IX: Annual Report, Delta Province, 1955, p.17; NAI, War prof 2, 235/1 Vol VIII: Annual Report, Delta Province, 1954, Enclusure p.5, p.11.

step towards the provision of hospital services in the rural areas for the first time. It had also met some of the demands for expansion of services in the urban centres. With the expansion of schools and churches, the number of Delta people predisposed to modern medicine continued to multiply. By the end of 1951, 546 primary schools with an enrolment of 40,584 pupils had opened in the province. In addition, four secondary schools with 728 students excluding teacher training colleges had been established.[14] By 1953 about 123,987 Delta people had professed the Christian religion, while about 56,211 had acquired the knowledge of reading and writing.[15] In 1955, when the Western Regional Government inaugurated the Universal Free Primary Education, primary as well as secondary school enrolments increased by about thirty percent.[16]

Likewise, the creation of regions and more local government areas in the Warri Province within the period resulted in an expansion of government workers who desired modern medical treatment. New local government headquarters developed into urban areas requiring modern facilities, befitting their new status, like dispensaries, schools and urban markets. Ughelli, Oleh, Orerokpe, Obetim Kwale and Aboh had become towns because of their position as local government headquarters. More importantly, the establishment of medical and health facilities

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14. Public Health Policy Western Region, p.3.

15. Annual Report, Delta Province, 1953, p.67.

16. Annual Report, Delta Province, 1955, pp.7, 18, 33, 42.

in the rural areas by the Christian missions and the NAs earlier demonstrated the efficacy of modern medicine in treating such diseases as yaws, leprosy and smallpox. With the growth of education and awareness, the town as well as the village dwellers had become so enlightened as to be dissatisfied with dispensary services. We noted in chapter four how sick people by-passed dispensaries to attend hospitals outside Aboh division in 1947. These developments resulted in a quest for more efficient medical treatment in hospitals especially as only the hospitals could handle more complicated disabilities requiring surgical operations and blood transfusion.[17] Thus, the popularity of the hospitals continued to grow both in the towns and in the rural areas as the years progressed. Between February when the Rural Health Centre ughelli opened and December 1955 it attended to 15,954 outpatients.[18] The old hospitals also continued to record unprecedented increases in their in-patient and out-patient attendances. Hospitalised patients in Forcados hospital increased from 110 in 1925 to 382 in 1945,[19] an increase of 274 percent in twenty years. Out-patient attendances in Warri General Hospital increased by 184 percent in nine years, rising from 13,406 in 1943 to 37,874 in 1952.[20] It was a general trend in all the hospitals. This trend became increasingly

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17. Interview with Umukoro Ighomor, A Traditional Healer, Aged 76 at Ozoro, 2-12-91.

18. Annual Report, Delta Province, 1955, p.62.

19. Nigeria *Blue Book*, 1925, p.217; NAI, War prof 1, WP 235, Vol. III: Annual Report, Warri Province, 1946, pp.65 & 87.

20. NAI, War prof 1, WP 235: Annual Report, Warri Province, 1944, p.38; NAI, War prof 2, 235/1 Vol. VI: Annual Report, Delta Province, 1952, p.38.

prominent during this decolonisation period following the indigenisation of the civil service. While most medical doctors were Nigerians, other ancillary medical personnel were Delta peoples. This probably inspired more confidence in some patients to attend hospitals as the problem of language barrier had been eliminated because some hospital staff were their relatives.

(2) Public Health Schemes

(a) Urban and Rural Water Schemes

The Revised Plan provided more incentives for LAs to develop urban water schemes. It increased free grants from the Development Fund from thirty to fifty percent of the cost of installation. In addition, the maximum period for repaying Loan Funds was extended from twenty-five to thirty years but the rate of interest remained steadily at three and a half per cent. The Warri Urban Water scheme, the only provincial scheme, received an allocation of £3,560 towards its completion.[21] The scheme was commissioned in 1952 after completion, remaining extension to the outlying areas of Okere, Odio, Ginuwa and Odiri where demands for extension had been approved. Extension of pipes to these areas was completed in 1955 after which the Public Works Department installed a standby

21. NAI, Sap. Dist. 1/1/171 Vol. I, p.101: Memo by Regional Deputy Director of Medical Services to Residents 8-12-50.

compressor to ensure the supply of treated water for twenty-four hours.[22] The Warri water scheme initially estimated to cost £15,000 eventually cost £19,340 because of inflation and extension to areas not included in the plan originally. The Warri LA started to repay this sum and its interest at the rate of £529 annually in addition to £193 for annual maintenance.[23]

Attempts to institute piped water in Burutu and Sapele within this period failed because of lack of financial support from the government. A proposal to pipe water to Burutu from Ejekute creek where there was fresh water turned out to be uneconomical at an estimated cost of £18,000 to which the regional government was not prepared to make any contribution.[24] Likewise, the Sapele LA could not finance its proposal for piped water without financial assistance from the regional government. Its consulting engineers Messrs Binnie Deacon and Courley provided an estimate of £135,000 in 1958.[25] Consequently, water supply

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22. NAI, War prof, WP 1200, p.205: Resident Delta Province to Permanent Secretary, Ministry of Works 9-3-55.

23. *Ibid.*, p.206: Ministry of Works Ibadan to Resident Warri Province, 13-4-55.

24. NAI, Ijaw (W) 2, BF 128, p.44: LA Office Burutu to Resident Warri 4-4-50.

25. NAI, Sap Dist 1/1/234, p.19-20: Ag. Perm. Sec. Ministry of Local Government to Sec. Sapele Urban District Council 10-4-58.

in these townships continued to be through concrete wells and tube wells provided by the government under the Rural Water Scheme as in the previous period. In 1954, the PWD sank three boreholes at Sapele, installed pumps to three tube wells sunk earlier at Burutu and provided catchment facilities in government quarters.[26]

Because of insufficient supply of water in these towns individuals resorted to constructing private wells in their compounds. The government encouraged this practice on condition that they conformed with the accepted standards for government wells: have concrete tops and lid lock and be accessible to government officials for regular inspections. This offered a solution to the problem of urban water supply for individuals and communities. By 1953 about 1000 private wells had been sunk in Sapele,[27] demonstrating not only the popular acceptance of policy but also the willingness of the Delta peoples to complement government efforts to expand modern facilities and services. The unsatisfactory nature of these private and public wells, which vitiated their usefulness were similar to the public wells provided by the government for the rural communities under the Rural Water Supply scheme and will be better discussed under that heading. Their short-comings, not withstanding, they helped to satisfy the serious need for potable and sufficient water supply in the towns.

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26. NAI, Ijaw (W) 2, BF 128, p.91-92: Township Office, Burutu to District Officer Western Ijaw Division 2-3-54.

27. Annual Report, Delta Province, 1953, Enclosure p.82, p.13.

Rural Water Supply

The Revised Plan introduced new measures for bolstering Rural Water Supply Schemes by providing for the installation of pumping equipment, tanks and pipes for wells deeper than 120 feet. The NAs were to bear the cost of these additional equipment as well as the distribution of mains where necessary. The government encouraged NAs embarking on projects under the new scheme by providing free grants of fifty percent of the cost of the additional equipment, similar to the arrangements made for the urban water scheme projects.[28] Actual conditions for sinking open wells remained as specified in the original plan. In 1950 an experiment for the sinking of tube wells started. This worked quite well and was adopted for use in addition to open wells.

Actual implementations of the Revised Plan under this scheme failed to satisfy the aspirations of both the policy makers and the consuming public. By the end of 1952, only eight out of thirty tube wells and ten out of 120 open wells approved for the Urhobo NA reached completion.[29] In 1953 the province

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28. NAI, Ughel Dist 1/825/2, pp.83; 87-88: Ag. CSG to Sec. Western Province 15-6-49; CSG to Sec. Western Province 15-7-49.

29. NAI, Ughel Dist 1/1354 pp.72; DO Ughelli to Provincial Engineer PWD 11-7-50; DO Ughelli to Native Council Presidents 9-6-50.

received an additional allocation of fifty tube and thirty open wells with twelve tube and eight open wells to be constructed in each division.[30] In subsequent years new wells were not sunk as there were no longer any alloations.[31] Thus, the revised plan failed to achieve the goal of providing "one point to supply some 500 persons living in rural communities with about three gallons of pure water per day per family."[32]

The main reasons for the failure of the scheme were the persisting shortage of materials and funds. All administrative officers constantly complained about these limitations. In 1951, the inspector of works for Rural Water Supply, Mr. D.B. Kohane, doubted the prospects of the tube wells because of lack of materials. In the following year, the Senior District Officer Urhobo division, Walter Kenneth Douglas Macray, complained of lack of supervisory staff and equipment.[33] Although the Revised Plan inherited the unused funds and uncompleted projects from the original plan, when those funds were exhausted work on many

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30. Annual Report, Delta Province, 1953 Enclosure p.75, p.13; NAI, Ijaw (W) W1 335/3: Annual Report, Western Ijaw, 1953, p.40.

31. Annual Report, Delta Province, 1954 Enclosure p.14, p.8, Annual Report, Delta Province, 1955, pp.7 and 17.

32. NAI, Ughel Dist 1/825/2, p.87: Memo, CSG to Sec. Western Provinces 15-7-49.

33. Ibid., pp.115, 172: DO Urhobo Division to Provincial Engineer PWD 20-11-50; Provincial Engineer PWD to Resident Warri 15-5-52.

schemes stopped. Sometimes the regional government provided additional funds but it tended to favour more visible institutions such as the establishment of dispensaries and maternity homes in the rural areas. One can observe that faulty planning, resulting in the non-implementation of most projects in the first phase, leading to the revision of the whole plan continued to affect the rural water schemes and stalled their implementation. Inadequate projection of costs resulted in shortage of funds leading to shortage of materials and staff.

Faulty implementation also detracted from the usefulness of the limited number of wells provided. Often the tube wells broke down while the open wells remained dry much of the time. In 1952, Kohane observed that out of the eight tube wells in the Ughelli district only one was working, while only one out of the seventeen open wells in the Urhobo/Isoko NA was satisfactory. The remaining wells remained dry because they were either shallow or had cracked or broken bottom rings. The depth of the wells in the Delta Province ranged between sixteen and twenty, whereas the plan stipulated a maximum depth of 120 feet for open wells. Understandably the water table could be reached within sixteen feet at some points in the Delta region especially during the wet season but would recede during the dry season hence most wells lacked water during the dry season. The dryness of the wells was also attributed to over use. Because of the insufficient number of wells for the populace they were subjected to incessant use whereas the

wells needed some gap to accumulate water.[34]

Recommendations by inspectors and administrative officers on how to improve the conditions of the wells were not heeded hence the poor conditions persisted. In 1952, Kohane recommended that most of the wells needed to go down ten or more feet deeper in order to reach the water table. He further recommended that the PWD should undertake the responsibility of maintaining the wells, otherwise the maintenance work would remain undone.[35] On the other hand, the Senior Divisional Officer Urhobo division, Macray, suggested that the NA should train their own staff to undertake maintenance work.[36] None of these suggestions was effected, and wells remained inadequate in number and not properly maintained. Meanwhile, most of the wells operated under very insanitary conditions as the sanitary inspector Western Urhobo NA, W.O. Agboghorom, observed that several wells had no covers at all, while dirty containers were used to draw water in most cases.[37]

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34. Interview with Peter Monday Okotie, Public Servant, Aged 52, Abraka, 23-4-95.

35. NAI, Ughel Dist 1/825/2, p.161: Inspector of Works PWD to Provincial Engineer PWD Warri 1-11-52.

36. Ibid., p.62: SDO Urhobo Division to Provincial Engineer PWD 18-1-56.

37. NAI, Ughel Dist. 1/1297/1, pp.87-88: Sanitary Report, San. Inspector W. Urhobo NA to President NA Council; NAI, Ughel Dist. 1/1720, p.69: Health Committee minutes Urhobo/Isoko NA - 28-4-55.

Ultimately, the goal of the Ten Year Development Plan concerning the provision of good drinking water through the Rural Water Supply scheme remained unrealised. Many people continued to drink impure water and scarcity of water continued leading to an unhealthy environment. Constant outbreaks of typhoid occured, whereas other water-borne diseases remained endemic.[38] A more effective water supply policy would have improved public health.

Urban Sanitation

Urban sanitation continued to pose serious problems as some new measures failed to improve the situation satisfactorily. Only in some areas in Warri, where water-borne sanitation was instituted in government residential areas and institutions and later extended to private individuals and companies after the completion of the Warri Water scheme did sanitation improve considerably. Outside these areas in Warri and in the Sapele township the problems of disposal of nightsoil by contractors continued as in the previous period. Even when Warri LA set up four collecting centres to reduce the distance nightsoil could be head-loaded before being carried to the trenching grounds, the problems of unsatisfactory services persisted.[39]

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38. Annual Report, Development and Welfare Schemes, 1952-53; Annual Medical Report, Western Region, 1954, p.38.

39. Annual Report, Delta Province, 1954 Enclosure p.12, p.1.

In 1952, Sapele reverted to disposal of nightsoil by direct labour under the supervision of the Sanitary Department. Initially, this proved successful but there were still complaints against some labourers who did not carry out their work satisfactorily in that year and in subsequent years.[40] In that same year, Sapele unsuccessfully experimented with composting of nightsoil. It failed mainly because of faulty planning and the negative attitude of the labourers. The chambers constructed for composting could only contain about one-tenth of the nightsoil collected, whereas the labourers refused to mix the excreta with vegetable before putting the ensuing mixture into the chamber. An additional problem that frustrated the composting system was lack of market for the final product resulting in the government disposing of the compost at its own expense. With the failure of composting, the Sapele LA reverted to the trenching system,[41] and in addition constructed aqua latrines to supplement the public bucket latrines and reduce the burden of disposal of nightsoil.[42] These measures, notwithstanding, urban sanitation remained an unsolved problem in our period of study.

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40. Annual Report, Delta Province, 1952 (Sapele township) p.23; Annual Report, Delta province, 1953. Enclosure p.82, p.13.

41. Annual Report, Delta Province (Sapele township), p.23.

42. Annual Report, Delta Province, 1953 Enclosure p.82, p.13.

Propaganda

In addition to the usual public lectures in schools, colleges, courts and local government councils to educate the public on health issues,[43] the provincial and Local Authorities started to organise health weeks in this period as a means of educating people on health care. The Sapele LA organised the first health week in the province in 1953 between October 26 and November 1. The second held at Warri between November 30 and December 5 the same year. Prominent activities included motion pictures of ideal sanitary environments, lectures on health care, daily baby shows followed by demonstrations on baby bathing and feeding. Additional activities at Sapele included competitions among schools and compounds on cleanliness after which prizes were awarded.[44] These activities no doubt widened the knowledge of the participants on a wide range of modern methods and procedures.

The leprosy control service also introduced a new dimension to its propaganda machinery. Because of the popular acceptance of modern treatment especially injections many lepers resorted to illegal injections from private providers of modern medicine. In 1950, the Area Superintendent alleged that no fewer than twelve centres giving illegal injections existed in the Benin and Delta Provinces. Therefore the provincial board resolved to intensify propaganga: public lectures and distribution of circulars in public institutions.[45] In addition the Leprosy Service published a pamphlet, *20 Questions about Leprosy with the Correct Answers* for distribution to public institutions and individuals to help

spread the gospel of leprosy control measures. The pamphlet gave all relevant information about leprosy covering the causes, kinds, methods of contact, symptom, effects, cure, need for isolation, why it should be controlled and how everybody could assist in the anti-leprosy campaign. The answers to question 20, "How can I personally help the Anti-leprosy campaign"?, run thus:

(1) If any member of your family is suspected of having leprosy consult a doctor without further delay.

(2) Having read this booklet, pass it on to your friends for them to read.

(3) Tell your towns people what is said in this booklet, and if their are patients with leprosy and no clinic to which they can go for treatment, urge a leading person to write to the doctor at the nearest settlement about it.

(4) If there already is a clinic offer your service as a voluntary social worker.[46]

This new approach, helped spread all necessary information about leprosy control

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43. NAI, MH/Fed/1/12010[8]: Annual Medical Report, Western Region, 1952/53, p.52.

44. Annual Report, Delta Province, 1953 Enclosure p.82, p.34; Enclosure p.79, p.22.

45. NAI, Ughel Dist 1/1422, p.22: Minutes of Benin/Warri Provincial Leprosy Board 30-8-50.

46. T.F. Davey, *20 Questions About Leprosy with the Correct Answers Produced and Published for the Nigeria Leprosy Services by the Federal Service* (Lagos: Government Printer, ND) pp.1-7.

to many Delta peoples hence more and more people, patients and communities continued to seek modern treatment for leprosy. Obviously, the educated class who had the privilege of reading this document did not relent in carrying out the instructions contained in question twenty elaborated above. In fact all lepers interviewed pointed to one relative or the other who directed him or her to Ossiomo or any other settlement.

Disease Control

(a) Leprosy

The Revised Plan modified the conditions for the establishment and administration of the three main institutions for the control of leprosy: the provincial centres, segregation villages and clinics. In view of the huge financial involvement and lack of personnel experienced in the first phase, in his report on financial aid to the missions, Phillipson recognised that the government would not be able to cope with Leprosy work without the missions.[47] Following his recommendation, the government decided to make subventions to the Christian Missions or other bodies for operating existing leper settlements instead of assuming direct control of such centres as originally intended. Moreover, the government encouraged the missions to establish new settlements.[48]

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47. Phillipson, *Report on Grants-in-aid to Voluntary Agencies*, p.36.

48. Annual Report, Development and Welfare Scheme, 1950/51, p.49.

The Leprosy control service, however, retained control of the provincial centres it had earlier taken over, so the Ossiomo Leper Settlement remained under government direct control.[49] It allocated £42,850 to Ossiomo settlement for physical development, administration and maintenance.[50] By the end of 1953, it had completed a new hospital block, semi-permanent quarters for patients and water installation.

As a result of an earlier decision to treat non-infective patients as outpatients in existing hospitals and dispensaries, the management of Ossiomo settlement introduced a new training programme in 1954. Dr. Langauer invited the NAs to send candidates for about six months training after which they could be employed to treat out-patient lepers in clinics attached to dispensaries for about two days in a week. Though a minimum educational qualification of government-class-four was required, the Area Superintendent accepted holders of standard six certificates. She did not charge any fees for the training. The trainees could also serve in segregation villages.[51] The NAs in the Delta Province, did not, however, welcome the idea of treating lepers in conventional dispensaries and even hospitals

49. NAI, Sap Dist 1/1/171 Vol.1, p.122: Memo to Leprosy Control, Scheme D.366 by Senior Leprosy Officer (ND).

50. Ibid.

51. NAI, Sap Dist 1/1/39, p.277: Area Superintendent, Ossiomo to Residents 1-9-54.

because it countered the traditional belief that lepers should not interact with other members of the society. The idea was dropped, thus illustrating the view that when a modern measure contradicted a traditional belief the people rejected it.[52]

The NAs and the RCM continued to contribute to the development of the Ossiomo centre thereby keeping alive the spirit of collaboration. In 1952, the NAs in Delta Province raised thirty-two pounds for erecting a hut at Ossiomo for Girl Guides and Brownies.[53] Likewise, the RCM built a three class-room block in 1955 for lepers' children with a grant of £600 from the government.[54]

Expansion of Segregation Villages

The Revised Plan introduced a system of grants for establishing segregation villages. Earlier, the responsibility rested solely on the communities. The Leprosy Control Service provided $33^{1}/_{3}$ percent while the NAs made available $66^{2}/_{3}$ percent of capital costs of buildings.[55] The NAs also started to assist the

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52. Ibid., p.284: DO Sapele to Resident Warri 20-10-54.

53. NAI, Ijaw (W) W1 432 Vol. III, p.536: Appeal by SDO Warri to NAs for Fund, 5-5-52.

54. NAI, Sap Dist 1/1/39; p.312: Report by Education Officer at Provincial Leprosy meeting 5-10-55.

55. NAI, Ughel Dist 1/1678, p.14: Minutes Benin/Delta Provincial Leprosy Board 3-3-52.

communities in maintaining the centres. For instance, in 1954 the Abraka camp received £150 and £600 for a ring well and pan roofing respectively.[56] During the first phase, the NAs were barred from assisting the communities in any way. The Leprosy Control Service continued with its usual responsibilities of providing for drugs, administration and staff.[57]

These new provisions enhanced expansion efforts in the segregation villages. Kwale division opened three more camps at Umuebu, Eberedemi and Emu raising the number to nine altogether. Between 1952 and 1957, the Ughelli division opened sixteen camps.[58] The Ijo division opened its first segregation village at Ayakoroma in 1954, whereas its second camp at Jeddo, provides a good illustration of a successful experiment in co-operation among various agencies in establishing one institution. Two NAs that lacked land: Ijaw and Itsekiri, and Warri LA shared 662/3% of the cost of erecting the buildings while the Leprosy Service provided 331/3 per cent from the Development Funds. The Western Urhobo NA which had established several villages on its own, provided land at a

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56. NAI, Ughel Dist 1/1482, p.56: DO Ughelli to Area Superintendent Ossiomo 5-8-1954.

57. NAI, Ughel Dist 1/1678, p.12: Minutes Benin/Delta Provincial Leprosy Board 3-3-52.

58. NAI, Ughel Dist 1/1482, p.56: DO Ughelli to Area Superintendent Ossiomo 5-8-1954; p.67: Minutes Urhobo/Isoko Health Committee 4-8-54, Leprosy Camps at Abraka, Eku, Orogun, Aghadu, Agharho, Ewu, Usere, Illu, Okpe, Okpolo (Enwe) Agbassah, Jeremi, Olomoro, Ughotor, Iyede and Emevor.

minimal rental. The RCM took charge of local administration, supervision and staff, while the Leprosy Control Service supplied drugs and free medical treatment in addition to overall supervision by a touring medical officer.[59] The community offered free communal labour for some of the manual work. In fact, the Jeddo community had earlier offered the site and wanted to build a village themselves before the sophisticated arrangement matured and necessitated giving out the work on contract.[60]

Leprosy Clinics

The Leprosy Control Service introduced two new policies concerning the establishment of more clinics within this period. We have noted the policy of attaching clinics to existing dispensaries and hospitals to treat non-infectious lepers and how the NAs resisted the policy. Only at Eku Baptist Hospital were lepers treated as out-patients following this policy.[61] In 1956, the Provincial Leprosy Board resolved and directed the NAs to erect two clinics costing about twenty pounds each in each district for the treatment of non-infectious patients

59. NAI, Ughel Dist 1/1678, pp.12-15: Minutes Benin/Delta Provincial Leprosy Board 3-3-54.

60. Ibid.

61. NAI, Ughel Dist 1/1482, p.41: Area Superintendent Ossiomo to DO Urhobo 13-3-54.

arguing that:

> It is more important to have treatment centres than to have more segregation villages because of a new drug... which takes about 5 years to cure a patient.[62]

There is no evidence that such separate clinics were established in the Delta Province. Rather, what the communities continued to ask for between 1956 and 1958 was segregation villages which invariably the divisional councils approved for them.[63] This further attests to the peoples preference for segregation.

Leprosy control measures remained popular with the Delta peoples throughout the period. Not only that they satisfied traditional assumptions about the need for isolation but they also introduced a humaneness that met new ideas about Christian concern and social welfare. The new system of grants-in-aid encouraged more communities to open segregation villages as we have noted earlier. Not only that they opened new segregation camps, most of the villages admitted more than the authorised number of patients most of the time. In 1951, the provincial centre had 1,100 in-patients instead of a maximum of 1,000 in addition to 5,000 out-patients.[64] Likewise, the six villages in Aboh division

62. NAI, War prof 2/426, p.24: Minutes Benin/Delta Provincial Leprosy Board 22-9-56.

63. NAI, Ughel Dist 1/1482, p.67: Minutes Urhobo Div. Council 4-8-58.

64. NAI, Sap Dist 1/1/39, p.312: Report by Area Sup. at Board meeting 2-10-51.

admitted 612 instead of 600 in-patients in addition to 1,372 out-patients.[65]

In many cases, the patients were more eager to be isolated than their communities. In 1951, about fifty lepers attached to the Eku Baptist Hospital petitioned the District Officer to influence their kinsmen to hasten the establishment of a segregation village. Each of them contributed ten shillings towards the project to demonstrate their enthusiasm.[66]

These positive responses by the communities and the lepers enhanced the control of leprosy within our period of study. It could not be eradicated mainly because of cases that had reached advanced stages resulting in various forms of deformity before admission to the centres. Nevertheless, reasonable success was achieved in the control of leprosy. In 1953, for example, out of 28,000 patients receiving treament in the government centres in Nigeria of whom 10,000 were isolated, about 6,000 were discharged that year.[67]

(b) Smallpox

The provincial authorities in collaboration with the NAs devised a new method for mass vaccination campaigns which enhanced the eradication of

65. NAI, Ughel Dist 1/1420, p.59: DO Ughelli to President Local Council Emevor 15-6-53.

66. NAI, Ughel Dist 1/1421, p.29-30: Lepers attending Eku Clinic to DO Ughelli 8-1-51.

67. Annual Report, Development and Welfare Scheme1952-53 (Kent, Her Majesty's Printer, 1953), p.40.

smallpox within this period. The NAs assigned sanitary overseers and inspectors to specific clans to carry out vaccination and house to house inspection on regular basis. With this method the vaccination exercise reached all the rural communities. Table XXXIII shows the vaccination returns from 1951 to 1954.

Table XXXIII

Vaccination Returns in Delta Province 1951-1954

Year	No. of Persons Vaccinated
1951/1952	50,473
1952/1953	30,914
1954	28,116

Source: NAI, MH/Fed/1/1/12616^{C} Annual Report, Western Region 1954, p.14

The decline in the number of persons vaccinated in some years did not reflect acceptance or non-acceptance by the people, it rather shows that, as the years progressed, less number of people qualified for vaccination or re-vaccination which could only take place after three years. Within this period inoculation against smallpox had been accepted as a means of preventing it. Consequently, the number of cases and deaths resulting from it declined dramatically. In 1953, only

two persons died of smallpox in Ijo division.[68] Only one case and no death occured in all the other divisions.[69] In the following year no death was recorded in the province as a result of smallpox.[70] During an outbreak of smallpox in Ijo division in 1957, intensified campaigns were carried out throughout the province and no death occured, indicating a successful control of the disease.[71] In fact, smallpox remained one of the endemic diseases in Nigeria and indeed Africa over which modern medicine triumphed.[72]

(c) Yaws

The campaigns for the eradication of yaws also achieved spectacular results. In chapter three, we noted the effectiveness of Arsenicals, Bismuth and Acetylersan injections for the cure of yaws and how they popularised modern medicine in the province. The most effective drug, penicillin, was introduced to Nigeria within this period. It was not only very effective in the cure of yaws, but was equally effective for the treatment of pneumonia and many other infectious

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68. Annual Report, Delta Province, 1953 Enclosure 88, p.21.

69. Ibid., Enclosure p.75, pp.11 & 12.

70. Annual Medical Report, Western Region, 1954, p.14.

71. NAI, Sap Dist 1/1/149, p.11: Health Office Sapele to DO Sapele on Vaccinations 14-1-57.

72. K. David Patterson, "Disease and Medicine in African History: A Bibliographical Essay" *History in Africa*, Vol. I, 1974, p.7.

diseases including gonorrhoea.[73] Though it was first used in Ghana and Brazil in 1944 it reached Nigeria in 1954 and was extensively used during WHO and UNICEF sponsored anti-yaws campaigns in Nigeria which started in the Nsukka area in the Eastern region in 1954. Yaws constituted one of the diseases the Medical Field Unit handled after its inauguration in the Benin and Delta Provinces in 1952.[74] Before 1960, yaws had been stamped out in the province as in other parts of the country and the British as well as French colonies.[75] C.J. Hacket contends that even before the WHO sponsored campaigns, improved sanitation had reduced the incidence of yaws in most provinces.[76] In fact, so few yaws cases occured that divisional reports for the 1950s in the Delta Province did not mention yaws.[77] This reinforced the popularity of modern medicine. Unhealthy trends also occured. In the 1940s and 1950s people consulted various practitioners for illegal injections while many medical officers went into private practice for the treatment of yaws neglecting their official duties.[78]

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73. C.J. Hackett, "Yaw's in *Health in Tropical African During the Colonial Period* eds. E. Sabben. Clare, D.J. Bradley and K. Kirkwood (Oxford: Clarendon Press, 1980), p.86.

74. Annual Report, Development and Welfare Schemes 1951-52, p.45.

75. Hacket, 'Yaws' in *Health in Tropical Africa*, p.90.

76. Hacket, 'Yaws' in *Health Tropical Africa*, p.83.

77. See Annual Reports, Delta Province, 1953-1955 for example.

78. Hacket, 'Yaws' in *Health in Tropical Africa*, pp.85-86. NAI, War prof 1, W.P. 437, pp.16-17: Resident Warri to Senior Medical Officer, Enugu 23-12-41.

Malaria

Efforts to eradicate malaria scored little or no success within our period of study. Only during this phase did routine inspection of premises reach the rural communities. The clearing of the environment and destroying or covering water containers constituted new teachings reaching the villagers the first time because limited personnel proved ineffective in spreading information about public health earlier. The lone overseer carrying out all sanitary duties in one or two clans this time was by no means sufficient to educate the people and supervise their environment. Even in the government stations and towns where mosquito control measures started as early as 1906 and where labourers took charge of environmental sanitation under the supervision of sanitary inspectors and overseers, the menace of mosquitoes continued. In 1951, for example, the health officer observed that, "there is density of Anophelis and other types of mosquitos" in the Kwale station,[79] indicating that even the government officials had not imbibed healthy habits especially as they concerned mosquito control. Even in such areas as Ilaro, Sokoto and Enugu Ezike, where a combined team of WHO, UNICEF, federal malaria control service and regional authorities carried out malaria control and eradication campaigns malaria continued to plague the people after the campagins.

79. NAI, Kwale Dist 1/739, p.3: Health Officer Kwale to MO Sapele 1-12-51.

In addition to preventive measures the Medical Department introduced new drugs for treating the disease: Mepacrine, Chloroquine, Daraprim and Paludrine. These drugs proved effective initially, but before 1958, Paludrine and Daraprim proved ineffective among some patients. Chloroquine and Mepacrine turned out to be more effective. Nevertheless, as long as mosquito eradication policies remained unenforced, malaria continued to be a scourge to the Delta peoples as well as to other Nigerians. Thus the problem of malaria control remained unsolved till 1960. Ralph Schram put it aptly:

> By independence, the position was one of a real beginning, but with a realisation also that Nigeria faced one of her biggest problems in the attempt at malaria eradication. The African fever of the Niger Expeditions, of trading hulks, of the Mission settlements and of the whole young child population of Nigeria was not yet beaten.[80]

C. Native Administration Health Activities

The Revised Plan instituted a new system of grants-in-aid to the NAs for the expansion of their medical and health facilities. In addition to the former ten per cent grants based on their annual expenditure on medical and health services, it introduced a capital grant of forty per cent of the cost of improving an existing dispensary or establishing a new health centre. They were also to receive £100 per annum for recurrent expenditure for the first three years of opening a fully equipped Rural Health Centre. The Western regional government introduced free

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80. Schram, *A History of the Nigerian Health Services*, pp.319-323.

medical treatment for school children. This attracted a grant of fifty per cent of the drugs purchased by the NAs. These grants fostered the expansion of health facilities during this period.

Another factor that enhanced the expansion of medical and health facilities in this period was the formation of local health committees following directives from the Director of Medical and Health Services, Dr. Samuel Layinka Ayodeji Manuwa, in 1951. Manuwa had hoped that the local committees would successfully plan the promotion of rural health services.[81] Between 1953 and 1954 NAs in the province inaugurated their health committees whose members were drawn from council members in addition to the medical doctor of the district and sanitary inspectors who offered expert advice.[82] The membership of the councils within this period comprised mainly the educated elite who favoured the development of modern medicine more than their predecessors. In 1950, for example, the Itsekiri NA passed a motion prohibiting the nomination of illiterates into any council of the Itsekiri NA.[83] The health committees took decisions concerning distribution of facilities, toured the existing facilities and participated in educating the populace. In 1953, for example, the Chairman of the Urhobo/Isoko

81. NAI, War prof 1, WP 74/4 Enclosure p.1968: Memo by DMS, SLA Manuwa to CSG 25-6-1951.

82. Annual Report, Delta Province, 1953 Enclosure p.75, p.13.

83. NAI, War prof 2, WP 116 Vol. II, p.368[A]: Minutes of Itsekiri NA 11-4-50.

federated NA, Chief A. Fiakporeh, toured all dispensaries in their NA taking note of their problems.[84] These members of council were elected following the rules of the Western regional local government reforms of 1952 which by 1955 had been effected in all the divisions. As members were elected on party basis they tried to fulfil their election promises and promote the image of their parties through a fair distribution of social amenities.[85] Furthermore, district officers ceased to act as LAs of the townships from 1955.[86] From that time local government passed to the indigenes who invariably distributed amenities equally to respective units in the province. These developments resulted in an unprecedented expansion of health facilities in the rural areas.

1. Expansion of Public Health Services

To effect a new strategy of locating sanitary inspectors and overseers to specific clans to carry out public health duties the NAs embarked on training or recruiting more health personnel inorder to raise enough staff. In fact, the Revised Plan stipulated that adequate staff, including a relief staff to make annual or sick leaves possible, must be available before a new institution could be opened.[87] In

84. NAI, Ughel Dist 1/1720, p.2: Health Committee Minutes Urhobo/Isoko NA 10-11-53.

85. NAI, War prof 2, 1503, Vol.II, p.248: DO Warri to Resident Warri 14-5-55.

86. Ibid., p.352: Resident Warri to DO Warri 26-9-55.

87. NAI, Kwale Dist 1/813, p.43: Memo by DDMS to Residents Western Provinces, 18-11-48; NAI, Ughel Dist 1/1550, p.7: Circular from Regional Medical Headquarters Ibadan to MOs 28-2-50.

1952, the Assistant Director of Medical Services, M.C. Letchie, further instructed that dispensary attendants-in-training should equal one-third of the existing staff for the latter reason to enable existing staff to go on refresher courses.[88] These new requirements compelled the respective NAs to recruit or train new staff. The number of sanitary inspectors and overseers, dispensers and Midwives trained under this programme within this period is shown in Table XXXIV below.

88. NAI, War prof 1, WP 74/4, p.27. Circular by Assist. Director of Medical Services, M.C. Letchie, to Residents 12-2-52.

Table XXXIV

Professional Training for NA Medical and Health Staff 1951-60 - Delta Province

Native Authority	Sanitary Inspectors	Sanitary Overseers	Midwives	Dispensers	Pharmacists
Ijo		2	2	2	
Urhobo/Isoko	1	6	3	9	1
Western Urhobo		6			
Warri (Itsekiri)				2	
Kwale			4		

Source: NAI, Ijaw (W) 5, Sanitary Overseers and Inspectors pp.557, 452, 523; War prof 2, 235/1 vol. VII: Annual Report, Delta Province, 1953, Enclosure p.88, p.21; Enclosure p.75, p.11; Enclosure p.77, p.19; Ughel Dist 1/1303: Health staff, pp.4 & 6; Ughel Dist. 1/1720, pp. 75, 30 and 76; War prof 1 WP 74/1: Dispensaries Urhobo Division, p. 16; Kwale Dist.1/813: Ashaka Maternity Home, pp.222 and 226.

We have noted how the new method of assigning sanitary inspectors and overseers to specific clans scored reasonable success in smallpox control. It also promoted the conduct of house to house inspections in the rural areas. The exercise did not, however, achieve as much success in other areas of public health as in the control of smallpox because the lone sanitary officer in charge of one or two clans could not have effectively supervised all sanitary measures in all the compounds. Nevertheless, available statistics on house to house inspection shown in Table XXXV below suggests that a good start had been made in instituting some sanitary rules in the rural areas.

Table XXXV

House to House Inspections in Native Authorities 1953/54

Native Authority	Year	Compounds Inspected	Satisfactory	Unsatisfactory	Remarks
Western Urhobo	1953	14102	10756	3346	-
Urhobo/Isoko	1953	13034	9526	3506	-
Western Ijo	1953	6274	-	-	-
Aboh/Ukwuaani	1954	9197	7510	1687	-
Itsekiri	-	-	-	-	Not available

Sources: NAI, War prof 2, 235/1 vol. VII: Annual Report, Delta Province, 1952/53, Enclosure p. 75, pp. 11 and 12; War prof 2, 235/1 vol. VIII: Annual Report, Delta Province, 1953/54, Enclosure p. 5 Appendix C.L. p.8.

Only vaccination and house to house inspections reached the rural areas within our period of study.

Other public health rules such as inpection of food items for sale to the public, public cooking or baking houses and rules governing building of houses were, however, extended to some hitherto rural areas which grew into small towns within this period. The headquarters of all local governments created before and within this period such as Ughelli, Orerokpe, Oleh, Obetim and Aboh had grown into small townships because of the presence of the secretariat and other public institutions: hospitals, dispensaries, maternity homes, markets, companies, schools and colleges. Other small towns such as Eku, Abraka, Ogume, Abbi, Obiaruku, Koko, Osoro, Ashaka, Patani, Akugbeme and Ogobiri also grew because of the existence of these public institutions. The above mentioned health rules which were enforced in the big towns in earlier periods were extended to these nascent towns within this period.[89]

With the enforcement of these rules in these towns, a good foundation for the prevention of diseases had been laid in them. It remained to extend these measures fully to the rural communities. Not only that, impressive number of houses were inspected and vaccinations adminstered, fewer deaths resulted from out-breaks of endemic diseases than before even in the rural areas.[90] The

89. NAI, Ughel Dist. 1/1720 p.17: Health Committee Minutes Urhobo/Isoko NA 25-3-54; p.44: Health Committee Minutes Urhobo/Isoko No. 13-7-54.

90. Annual Report, Delta Province, 1952/53 Enclosure p.75, pp.11 & 12; 1953/54 Enclosure p.5, Appendix C.L. p.8.

prosecution of persons who defaulted health rules in these towns and in the villages further compelled the people to comply to health rules. In the Western Urhobo NA, for example, forth-one persons were prosecuted for contravening various health rules in 1952 while thirty-one of them were convicted. They paid fines totalling £45:2:6. Whether the defaults were deliberate or out of ignorance they indicated that the health rules had not been well apprehended.[91]

Allegations of corrupt practices against the sanitary officers also helped some defaulters to evade the law. A notable allegation concerned receiving bribes in various forms from some communities or individuals in order to relax some public health rules for them. Consequently, either they did not visit their compounds at all or they ignored giving abatement notices when they were supposed to do so.[92] Denying allegations of corrupt practices by sanitary officer, Jacob Johnson Agoreyo, a retired sanitary inspector, admitted that "most communities were generous to the sanitary overseers" who did the field work, but maintained that it did not stop them from carrying out their duties to their conviction because senior health officers: Sanitary Inspectors and Health Superintendents, supervised their work and usually held them responsible for any nuissance discovered within their area of operation.[93] Inspite of any

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91. Annual Report, Delta Province, 1952, Enclosure p.14, p.8.

92. Interview, Okotie, P.M.

93. Interview with Jacob Owho Johnson Agoreyo, Retired Sanitary Inspector, Aged 70, at Okpara-in-Land 25-4-95.

irregularities on the part of the sanitary officers, the fact remains that regular inspections of compounds and working places reminded the Delta peoples of the need to keep their compounds clean by modern standards.

2. Expansion of Dispensary Services

In addition to the new system of grants-in-aid to the NAs under the Revised Plan discussed earlier, the Western regional government gave a block grant of £3,200 to each division for the establishment of new dispensaries.[94] These grants resulted in an unprecedented expansion of dispensaries in the province. Many new ones were built while some old ones were reconstructed. Table XXXVI illustrates the extent of expansion and reconstruction of old ones within this period.

94. NAI, War prof 2, 235 Vol. XII: Annual Report, Delta Province, 1955/56, p.8.

Table XXXVI

Expansion of Dispensaries in Divisions, Delta Province 1952-60

Division	No. Recon-structed	No. of New Ones	Location of New Ones
Itsekiri	2	6	Koko, Gboramoda, Ode Itsekiri, Jelu, Abegborodo and Opuma.
Aboh	1	7	Iselegu, Okpai, Abedei, Amai, Ase, Ogume, Obiaruku.
Ijo	1	4	Ojobo, Burutu, Nun-River, Okrika.
Urhobo	3	16	Ewu, Owahwa, Ovbakwa, Igbidi, Edjorovbe, Ivrogbe, Gboragolo, Orogun, Agbassa Ogelle, Agbudu, Uwerun, Ovbodokpokpor; Agbassah, Adadhe, Olomoro, Aviara.

Sources: NAI, War prof 2, 235/1 vol. VII: Annual Report, Delta Province, 1953, Enclosure p. 14 p.8; Enclosure p.77, p.20, Enclosure p. 88, p.22; War prof 2, 235/1 vol. VIII: Annual Report, Delta Province, 1954, pp.7, 10, Appendix VIII; War prof 2, 235/1 vol. IX: Annual Report, Delta Province, 1955, p. 42; War prof 2, 235 vol. XII: Annual Reprt, Delta Province, 1955/56, p. 8; War prof 2, 1030/6: Warri Divisional Council Minutes, Medical and Health Committee, 1956, p.3; Kwale Dist. 1/74/2: Dispensaries, pp. 93, 99, 155; Kwale Dist 1/813: Ashaka Maternity Homes, pp. 172 & 195; Ijaw (W) 4 WI 335/3: Annual Report, Western Ijaw 1953, p.70; Ughel Dist.1/1720: Health Committee Minutes 1952-1955, pp.2, 4, 30, 36 and 75.

The Urhobo division witnessed the greatest expansion of dispensaries. This corrected the existing imbalance in the distribution of dispensaries among the divisions and districts before this period. It was the largest division with about two-thirds of the population of the province and also occupying about two-thirds of its land area but these facts did not reflect in the distribution of amenities before this time. The health committees adopting traditional criteria for sharing had to correct the imbalance. In the application of the Western regional local government law of 1952 to the province, three districts: Western Urhobo, Urhobo and Isoko were created in the rural areas of Urhobo division excluding Sapele urban district.[95] Within these districts in the division all the new dispensaries were sited in the hitherto neglected Urhobo and Isoko district areas, while only reconstruction work was done in the old dispensaries in the Western Urhobo district that already had six dispensaries.

Some NAs also assisted the Christian missions in their area to maintain and operate their dispensaries. For example, the Aboh NA granted £150 for reconstruction and £60 for drugs to the CMS on behalf of their dispensary at Umuolu in 1953. It also procured £107:12:6 from the Community Development Funds for the same project the same year.[96]

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95. NAI,

Dispensaries, however, failed to regain popular support in this period, despite the investment of official funds. To make them more attractive the provincial authorities offered free medical treatment to adults in 1954, but this measure also met with failure. D.B. Patridge, District Officer Western Ijo division, rightly lamented the unpopularity of dispensaries,[97] but came up with no solution.

Although the unpopularity of dispensaries started with the introduction of dispensary fees in 1936, many other problems manifested themselves later and vitiated their services to the extent that the removal of fees could not revive initial popular acceptance.

The later problems centred on fundamental issues of health and healing. While assessing the work of NA dispensaries, the Deputy Director of Medical Services Western Region, D. Murray, blamed their poor performance on mismanagement by the NAs. He observed that:

> So often the dispensary is constructed to satisfy local prestige or to further the interest of other political factions amongst the members of District Councils and with the first careless rapture of the new dispensary is (sic) over the unit degenerates into a first aid post for children's cuts and abrasions... They considered that with the official opening ceremony their responsibilities are entirely at an end. ... In general the annual votes are inadequate, the supplies of drugs and dressings fail, the premises become shabby and deteriorate, the equipment becomes deficient and requests to councils for replacements and additions are frequently ignored.[98]

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97. Annual Report, Delta Province, 1954 Enclosure. p.2, p.10.

98. Annual Report, Delta Province, 1954 pp.40-41.

There is enough evidence from the management of NA dispensaries in the Warri Province, within this period, to support the very important issues of inadequate funding, lack of drugs and equipment raised by Murray. They constituted the bane of NA dispensary services. There is proof that medical and health services did not represent a priority area for the NAs in the province. In the previous periods they allocated between five and nine percent of their annual expenditure to medical and health services whereas education got about fifteen percent.[99]But despite the expansion of dispensaries and other health services, votes to medical and health services which went mainly to drugs and maintenance rather decreased instead of increasing correspondingly with the rate of expansion. In the 1955/56 and 1956/57 financial years, the Warri NA voted 4.7 and 5.15 percent respectively of its annual expenditure to medical and health services whereas it voted 70.4 and 59.16 percent respectively to education.[100] Thus, confirming that medical services were poorly funded. Other problems of the dispensaries were corrollaries of inadequate funding by the NAs.

Inadequate funding manifested in lack of drugs, maintenance and necessary equipment which were common features in NA dispensries in the previous, as well as in this period. The inspection report of F. Oputa, a member of Western House of Assembly on the government dispensary Obetim Kwale described these

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99. NAI, Kwale Dist 1/141 Vols. IX & X: Annual Reports, Aboh Division 1941, pp.73 and 77; 1942, pp.129 & 131.

100. NAI, War prof 2, 25 Vol. XI, p.4: Itsekiri NA Estimated 1955/56; Vol. XII, p.12: Itsekiri NA Estimates 1956/57.

deficiencies very aptly:

> Visited the Dispensary Jan. 15th 1953, the Dispensary is in itself a disgrace to the NA. The building is falling, the dressing room is attached to the Dispensary section of the clinic. Sanitary equipments (sic) are stored in the Dispensary. There are no drugs. It is surprising that all these yearsnot a single District Officer has made any serious move to approach the authorities concerned for a new building and a regular supply of drugs.... On the whole the present Dispensary is a disgrace to the community and all officers connected with the dispensary directly or indirectly are to blame.[101]

Lack of drugs and equipment affected the main issue of healing. We recall that patients in Aboh division complained of receiving treatments that were not "strong enough" and expressed their preference for injections which the dispensers, except those in Ijo division, were not authorised to give. To bolster the performance of the dispensaries, the District Officer Kwale division Robert Granville Biddulph suggested in 1955, that all dispensers should be allowed to give injections, but the policy did not change and people remained dissatisfied with dispensary services.[102]

Murray and Oputa even failed to identify one of the most serious deficiencies in the management of NA dispensaries namely, the employment of unqualified and inefficient dispensary attendants. Although the NAs started training

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101. NAI, Kwale dist 1/74/2, p.126: Rural Medical Officer, GC Azie, to SMO Benin 20-1-53.

102. Annual Report, Delta Province, 1955, p.17.

professionals during this period, the first generation dispensary attendants who received training as layworkers in the Warri or Sapele hospitals and others who did not even receive any formal training were still in charge of most dispensaries. In 1952, Biddulph discovered that Mr. A.C. Ogiemware, the assistant incharge of the government dispensary:

> Has never had any medical training. He was formerly employed as a time keeper and headman of a labour gang at Jericho Nursing Home and as a Messenger in the Senior Medical Officer's Office. During that time he claimed to have picked up some knowledge of medical department work.[103]

Their incompetence manifested in their negative attitude to work especially negligence of duty. In 1953, as in 1949, the attendant in charge of the Abraka dispensary could not be found anywhere in the premises when an inspection team visited the dispensary even though he left the dispensary open. The claim that he went to treat a wound in the village was not corroborated. Similar reports were common.[104] Because of these factors the popularity of dispensary services continued to wane and people had to seek modern medical treatment from hospitals and other providers including quacks with only school children and workers receiving free treatment and few others seeking treatment for minor complaints left to attend the dispensaries.

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103. Annual Report, Delta Province, 1954, pp.40-41.

104. NAI, Ughel Dist 1/1/1075, p.15: Inspection Report by Ag. Assist. DMS Western Provinces 13-5-49; p.35: Inspection Report by Doctor Cooper 7-11-53.

3. Expansion of Maternity Services

Before the inauguration of the Revised Plan, maternal care in the rural communities had lagged behind other modern medical services. Except for a modern maternity home at Ughelli, no other NA had opened a maternity home before 1951. The Revised Plan provided that maternity homes should exist side by side with dispensaries in order to institute rural health centres. All divisions complied with this provision and it boosted the expansion of maternity homes to satisfy the great need and quest for maternal services in the rural communities. The Western regional government also granted £4,800 to each division for the opening of four maternity homes. Table XXXVII shows the degree of expansion of maternity homes within this period.

Table XXXVII

Expansion of NA Maternity Homes in Divisions, Delta Province 1952-60

Division	No. of New Homes	Location	Remarks
Urhobo	8	Ejoroube, Emevor, Okpara-in-land,Jesse, Tori, Otor- Udu, Orerokpe, Ewu	The old Ughelli Maternity was transferred to Ewu in 1952
Warri	4	Ogbombiri, Saba, Beter and Gborodo	
Ijo	5	Bomadi, Burutu, Patani, Ojobo and Okrika.	
Aboh	6	Ashaka, Ogume, Ase, Aboh, Abedie and Onicha.	

Sources: Ughel Dist.1/1720: Health Committee 1952-57 p.75; CSO/2/11857, vol. XVIII: Annual Report, Warri Province, 1941 onwards (1951), p.22; Ughel Dist. 1/1750/1: Maternity Centre Orerokpe, p.11; Ughel Dist.1/1550: N.A. Dispensaries and Maternity Homes, p. 354; War prof 2, 1030/6: Warri Divisional Council Minutes, Medical and Health Committee 1956, p.3; War prof 2, 235/1 vol. VII: Annual Report, Delta Province, 1953 Enclosure p.77, p.19, Enclosure p.84, p.7; War prof 2, 235/1 vol. VIII: Annual Report, Delta Province, 1954, Enclosure p.2, p.10.

Some NAs assisted the Christian missions in their maternal services. The Urhobo/Isoko NA, for example, handed over its clinic at Ughelli to the CMS when it transferred its maternity to Ewu in 1952. It also gave the CMS a grant of £300 to support its maternal work at Ughelli in addition to an annual grant of £50.[105] The CMS had dominated maternal services in that division since 1930 and proved very popular in its services to the generality of women. With its members who received regular sermons and lessons on cleanliness and modern methods forming the core consumers of its services others followed. Therefore, their homes suffered no problem of patronage as the NA homes established later. In recognition of their place in this aspect of modern medicine the NAs decided to give them financial support unlike in the previous period when they turned down a request for such a support from the CMS.

Despite demands for modern maternal care services and the exapansion of NA maternity homes, within this period, a marked preference still existed for traditional birth attendants and care among the majority of women, even a good percentage of Christians. In 1950, for example, Dr. B.J.Ikpeme, Medical Officer Forcados, commented on the relationship between women's preference for traditional delivery methods and buttressed cultural beliefs about women's roles.

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105. Annual Report, Delta Province, 1952 Enclosure p.14, p.8.

He remarked that:

> The belief by the natives that pregnancy is the woman's concern and as such she must handle it alone and even be able to cope with eventualities single handed or at least unaided by males has seriously shaken the faith of even the literate element in the ability of the hospital to cope with maternity work.[106]

Ikpeme thus affirmed our conclusion in chapter three on the general attitude of most mothers to modern maternal services initially.

Though the trend continued, this period witnessed a remarkable change with more and more mothers attending hospitals and maternity homes for all maternal services: prenatal, delivery and postnatal. Undoubtedly, this resulted from the unprecedented expansion of Western Education in this period and missionary as well as government propaganda which from this period had included demonstrations on maternal and baby care during health weeks. But perhaps, because of their education or experience the mothers started to select hospitals or maternity homes to attend for all or some natal services provided by the modern institutions. For example, while 276 out of 786 antenatal patients (35 percent) who attended Warri General Hospital in 1950 gave birth in the hospital, twenty-five out of fifty-four mothers (46 percent) who received antenatal care in Dr. Fredrick Esiri's private hospital in Warri in 1953 gave birth to their babies in the hospital. Also in 1953, the number of deliveries equalled antenatal cases in Mrs.

106. NAI, War prof 1, 235/1 Vol. IV: Annual Report, Warri Province, 1950, Enclosure p.90, p.11.

O. Nelson William's Nursing Home and Clinic, whereas deliveries exceeded antenatal cases in the Blissful Maternity of Mrs. P.R. Knox in 1954.[107] Deliveries exceeding antenatal cases suggests that mothers who attended other maternity homes for antenatal treatment preferred Mrs. Knox's clinic for delivery.

Humane and sensitive treatment to mothers in labour has been identified as a major reason attracting mothers to some private clinics and traditional birth attendants. According to Chief Florence Elemi-Rewane, who underwent graduate studies in Midwifery and Nursing and served the Western regional government within the Delta province between 1957 and 1960 when she opened her private maternity home, the mothers preferred private clinics because they were treated with kindness and respect. She explained that Mrs. William's and Mrs. Knox's humane treatment to mothers attracted them to their clinics hence deliveries equalled or exceeded prenatal cases. Conversely, in government hospitals and maternity homes mothers in labour were scolded and even beaten and that scared them from such institutions. According to her, her own private maternity home opened in November 1960 recorded over eighty per cent deliveries of prenatal cases because most mothers who appreciated her kind assistance to them when she served in the General Hospitals turned to her clinic. She also believed that the ill treatment meted to mothers in labour was a major reason why some mothers

107. NAI, MH/Fed/1/1/12250J: Annual Medical Report (Private Medical Activities) 1953/54, p.2.

continued to seek the assistance of traditional birth attendants.[108] This corroborates the view of some female informants that the traditional birth attendants were more gentle, efficient and tolerant.[109]

By 1960, township mothers preferred maternal services but most rural mothers still remained sceptical. In 1955, for example, the Medical Officer Ijo division, Dr. H.E.O. Adefope, deplored the attitude of rural mothers to modern natal services when he observed that the Bomadi maternity home rarely recorded more than two deliveries a month and recommended that only effective propaganda could improve the situation.[110] Mrs. Margret Erusiafe, a qualified midwife and nurse, who had served in both urban and rural maternity homes affirmed the differential acceptance of maternity services by urban and rural communities by and beyond 1960.[111] To educate the rural woman to accept modern natal services in all its ramifications remained an uncompleted task by 1960.

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108. Interview, Chief Florence Elemi-Rewane, A Retired but practising very well qualified Midwife and Nurse Aged 66, at Warri, 1-5-95.

109. Interviews with Lucy Onodavwerho an old mother Aged about 85, at Abraka, 2-5-95; Aruerue Ogbokor, Traditional Birth Attendant, Aged 69, Iye-Rughe Isoko, 12-12-91.

110. Annual Report, Delta Province, 1955, p.42.

111. Interview with Margaret Erusiafe a qualified Nurse and Midwife, Aged 39, Abraka 26-4-95.

D. Non-Governmental Agencies

The Colonial State continued to collaborate with and encourage the non-governmental agencies: the Christian missions, commercial companies, private doctors, nurses, midwives and patent medicine dealers to expand modern medicine under government supervision.

1. Medical Work of the Christian Missions 1951-60

Following Sir Sydney Phillipson's recommendation, the government incorporated into the Revised Plan grants-in-aid to the Christian missions for:

> The purpose of extending existing hospitals or of building new combined hospitals in areas considered to be medically badly underserved and which no medical facilities are at present available.

It allocated the sum of £50,000 for such grants to the Christian missions in the Western region. The region allocated £20,000 to each of Oyo and Ondo Provinces for the SDA mission hosptial at Ife, the Wesley Guild Hospital Ilesha, RCM Hospital Owo and the Anglican Maternity Hospital and Nursing Training Centre at Ado-Ekiti. The Benin Province received £10,000 for the RCM "combined" hospital Ogwashiuku.[112] No funds went to the Delta Province because the Eku

112. NAI, Sap Dist/1/1/171 Vol. I, p.119: Nigerian Secretariat Lagos to Sec. Western Provinces 12-7-50 on Revision of Ten-Year Development Plan.

Baptist hospital rejected such a grant when it was proposed to it in 1950.[113] Again, the missionary medical activities in the province did not draw inspiration from the Development Plan but were rather a continuation of their medical work which started in 1930. They, however, received some financial assistance from the NAs as a result of local arrangements.[114]

The CMS undertook reconstruction work and consolidation of services at its old centres. Apart from the NA maternity home at Ughelli handed over to it to manage with some financial assistance from the Urhobo/Isoko NA,[115] it did not open any new centre within this period. It rebuilt the Umuolu dispensary and maternity home in 1953. The reconstruction of the CMS dispensary at Umuolu offers another good example of collaboration among different agencies in trying to achieve a common objective. The community provided voluntary labour, the NA gave both capital and recurrent grants, the Resident provided some money from the Community Development vote, while the CMS that established it initially continued with the management.[116]

113. NAI, Ughel Dist 1/289, p.47: Divisional Medical Headquarters Benin City to DDMS Western Provinces 22-7-50.

114. NAI. Ughel Dist 1/1678, pp.12-15: Minutes Benin/Delta Provincial Leprosy Board 3-3-54.

115. Annual Report, Delta Province, 1952, p.39.

116. NAI, War prof 1, WP 206/4, p.33: His Honour's (Sir Chandos) Reply to Address of Welcome at Umuolu 16-10-51.

Like the CMS, the Baptist Mission concentrated efforts on the development of its existing hospital at Eku. By the end of 1957 the hospital had expanded its number of beds from thirty-two in 1950 to seventy-three. It also undertook to train some medical personnel. In 1953, Dr. J.B. Gaultney and his wife opened a laboratory school for training technicians. The plan to transfer the school of nursing at Ogbomosho to Eku materialised in 1960 when the students and their staff moved to Eku to mark the beginning of accredited nursing education in the Delta Province.[117]

Only the RCM embarked on an expansion policy in this period. It secured approval and established an eight bed maternity home at Umutu which would also serve as an Infant Welfare Centre to be supervised by Dr.Clatworth from Ubiaja and the Sister incharge of St. Philomena's Maternity Training Centre Benin.[118] It also got approval to establish a ten-bed maternity home at Ozoro in 1955. It could not build the centre immediately because it failed to secure a grant of £1,000 from the Resident to enable it to embark on the project.[119] It later established a maternity there in 1958.

117. History of Eku Baptist Hospital: Paper Presented at the 40th Anniversary of the Hospital by the Baptist Church Commiteee, 1990, p.2.

118. NAI, War prof 1, WP 206/4, p.39: Med. Dept. Benin to Resident Delta Province 4-12-52, p.40: Resident Warri to DO Aboh 10-12-52.

119. NAI, Ughel Dist 1/289, p.48; RCM to SDO Ughelli 26-8-55; p.49: SDO Ughelli to RCM 23-4-55.

Thus, the Christian missionary activities continued to complement the medical work of the different arms of government especially in the rural areas where, in fact, they pioneered modern medical services.

2. Medical Work of Commercial Companies

Operating under the Private Hospital Ordinance Number 52 of 1945, discussed in chapter four, the commercial companies in the Delta Province also expanded their medical work to more branches of their establishments and also to satisfy their growing labour force. The UAC founded a maternity hospital at its Sapele Rubber Estate in 1952, and two dispensaries at its Timber Estates at Burutu in 1953.[120] Also in 1953, it opened a hosptial comprising male and female wards, a maternity ward, an isolation ward and a "fully equipped operation theatre" for its Niger Transport Division at Burutu.[121] In the following year, it founded a dispensary at Koko for the Bulk Oil Division and a hospital at its African Timber and Plywood factory at Agbaje Sepele where it had earlier opened a dispensary. Though the hospital opened by the Minister of Public Health, Western Region, was intended to render out-patient services, it had provision for about ten in-patients.[122]

120. NAI MH/FED/1/1/12010J: Annual Medical Report, Western Region, 1952/53, p.5; Annual Medical Report, Western Region, 1954, p.21.

121. Annual Medical Report, 1954, p.22; Annual Report, Delta Province, 1954, Enclosure p.2, p.28.

122. Annual Medical Report, Western Region 1954, p.21.

We have stated earlier that these company medical institutions which gave free medical treatment to their workers and their relatives also treated non-workers who paid for their treatment.[123] This helps to explain the high number of in-patients and out-patients attending them. For example, the UAC clinic at Sapele, the Cowan Estate Hospital Ajagbodudu and the Cowan Estate Maternity Ajagbodudu, recorded 13,732, 12,578 and 6,851 out-patients and 666, 60, and 36 in-patients respectively in 1953.[124] Like the Christian missions the commercial companies complemented the medical work of the governments in the areas where they operated.

3. Private Medical Practice

Following the recommendations of Sir Sydney Phillipson on the private practice of medicine by doctors on government service, the government banned doctors in its employment from private practice because, in the past, it led to negligence of official duties. Rather, it decided to use doctors on full-time private practice for its expansion programme within this period. Such full-time private practitioners would receive encouragement from the government in several ways, provided they established in areas considered to be unserved or underserved. Those working in groups could be provided with facilities for fully equipped health centres from public funds, whereas individual practitioners could receive a

123. Annual Report, Delta Province, 1954. Enclosure p.2, p.28.

124. Annual Medical Report, Private Medical Activities 1953/54, p.2.

subsidy or basic retaining fee from public funds. They could also obtain loans to set up medical institutions in underserved areas. There was also provision for building and equipment grants for community hosptials staffed by private practitioners working in a group "provided that these hosptials fit in with Government's scheme for hosptial expansion".[125]

This new policy which came into effect in April 1950, resulted in further expansion of medical services through the activities of private practitioners. As the new policy did not favour doctors in government service many of them, who were dissatisfied with the ban on them for private practice, resigned their appointments with the government to open proprietary medical institutions. According to Dr. F.O. Esiri who had been in government service since 1937, this was the only profitable alternative for those doctors who could not tolerate the ban because they were not satisfied with government salaries.[126]

The expansion of medical services through private practice in the Delta Province within this period resulted from the activities of this category of doctors and other medical personnel, nurses and midwives, who were equally affected by the ban, who resigned and opened private institutions. Dr. Folarin Ogunro opened the Eastern Drug Depot Dispensary at Sapele in 1951, while Mrs. P.R. Knox and

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125. *Statement of the Conclusions of the Government on the Report of the Commission on the Private Practice of Medicine and Surgery*, pp.4 & 5.

126. Interview with F. Esiri, Private Medical Practitioner since 1951, Aged 83, at Warri 2-2-93.

Dr. F.O. Esiri founded the Blissful Maternity and the Esiri Infirmary (hospital) respectively at Warri the same year.[127] In the following year Mrs. O. Nelson Williams founded a maternity clinic and nursing home at Warri while Mrs. G.E. Adigwe established a maternity home at Umutu and later at Sapele.[128] Florence Elemi Rewane opened the Numa Clinic and Maternity in November 1960.[129] As the policy makers anticipated these private institutions not only extended medical services to underserved areas, they also relieved "excessive pressure on many Government out-patients departments" because most of them were located in Warri and Sapele where government hospitals concentrated. They also proved very popular among the Delta peoples and were very well attended. We have earlier noted, in this chapter, that it was in these private maternity homes and hospitals that child-delivery by mothers equalled or exceeded prenatal cases.[130]

Patent Medicine Dealers

Dealers in patent medicine continued to be popular providers of modern medicine because of the advantages they had over government institutions which we discussed in chapter four, and for the fact that services rendered by other

127. NAI, MH/Fed/1/1/11841[C]: Annual Medical Report, Private Medical Activities 1951/52, p.3.

128. Annual Medical Report, 1953/53, p.5.

129. Interview, Rewane.

130. See Footnote 120 (this chapter).

agencies were still very much in short supply while demand for modern medicine continued to rise. Though the government had recognised the importance of their services it still viewed their activities as constituting a problem requiring control. By the end of 1950, the Medical Officer of Ijo division, Dr. B.J. Ikpeme, complained about illegal practices of medicine thus:

> These are a serious problem in the division as they are on the increase daily...(and) in some areas they receive the blessings of some councillors.[131]

We noted in chapter four that after the ban on the issue of licences the dealers continued practising without licences or renewal and so their number continued to increase. By June 1954 patent medicine stores had been established in many rural communities and nascent towns such as Abraka, Orogun, Ashaka, Obiaruku, Eku, Kokori-in-land, Okpara-water-side, Ozoro, Ivrogbo, Orho-Agbarho, Okwagbe water-side and Arhaubere thereby expanding modern medical practice more than any government agency.

Government fears about uncontrolled practice of patent medicine however, became justified when in 1954, three people died of poisoning from pills they bought in a market stall at Warri.[132] The government finally resolved the question of the appropriate licencing authority for patent medicine business in 1955 and still vested the function on the Residents. But the licencing system could not control

131. Annual Report, Warri Province, 1950, p.22.

132. Annual Report, Delta Province, 1952, Enclosure p.14, p.8.

the activities of patent medicine dealers due to lack of adequate staff to check the stock of medicines they sold or used in their treatment as to know when they exceeded their bounds. Nor did anything stop unlicenced dealers from practising. They continued hawking and administering illegal injections which had unfortunate consequences on their clients.

The evil effects of their practices notwithstanding, they played an important role in the expansion of modern medicine to the remotest parts of the province. Even in the towns, they competed favourably with government institutions because their services were in high demand thereby demonstrating the inadequacy of government services. The quest for modern medicine from qualified as well as from unqualified hands continued unabated till the end of our study period and demonstrated the popular acceptance of modern medicine.

Assessment of Policy and Implementation

The implementation of the medical and health programmes under the Revised Plan between 1951 and 1960 including the medical and health activities of the non-governmental agencies marked the culmination of the achievements of the colonial administration in the development of modern medicine in the Delta Province by 1960. Going by the view of R. Hunt Davis on the impact of colonialism, the Delta Province and Nigeria at large had been really inducted and

indoctrinated into contemporary global medical culture.[133] This is pertinent especially when viewed from the perspective of executing physical projects enunciated in the Ten Year Plan of Development in which the colonial administration could be credited with making significant achievements because it successfully executed most physical projects proposed for the province. It extended existing hospitals at Warri and Sapele, provided a mobile dispensary in place of expanding the Frocados hospital, opened the Ughelli Rural Health Centre and a rural hospital at Obetim Kwale, instituted a Mobile Field Unit and completed the Warri Urban Water Scheme project. Even though a sufficient number of wells were not sunk under the Rural Water Supply Scheme, as envisaged in the plan, a reasonable number of wells were sunk in the rural communities and also in the other towns.

The NAs, with financial support from the federal and regional governments also achieved an unprecedented degree of expansion of dispensary and natal services including child welfare to the rural areas. While the provincial authorities instituted all public health measures in the towns, the NAs extended vaccination and house to house inspections to the rural areas. Significant success was also achieved in the control of some endemic diseases especially yaws and smallpox. With the medical work of the Christian missions, commercial companies, communities, individuals including patent medicine practitioners, one can posit that by 1960, there had been a fair distribution of medical and health institutions in the

133. R. Hunt Davis, "Interpreting the Colonial Period in African History". *African Affairs* 12, 1973, pp.383-400.

Delta Province with each clan having at least one government institution located in its area in addition to institutions managed by non-governmental agencies.

These achievements were, however, more apparent than real if we examine the core issue of effective healthcare delivery. Except the hospitals which were very few, Warri Urban Water Scheme and leprosy segregation institutions, all other government institutions had serious lapses which vitiated their effectiveness. Most of the time the government dispensaries lacked drugs, equipment and efficient staff. Apart from school children and workers, receiving free medical treatment, only very few people went for dispensary treatment and for minor injuries only. The establishment of maternity homes by the NAs was so belated that by 1960 rural women still remained very sceptical about modern natal services. Only town, and very few educated women living in the rural areas had accepted maternity services fully. The tube wells as well as the open wells sunk in the rural areas and most towns either broke down completely within a year or two or remained dry most of the time especially during the dry season when people needed them more. As a result, only a few endemic diseases treated with injections, inoculation and isolation: yaws, smallpox and leprosy were effectively controlled. This explains why the demand for injections which led to patronising quacks was high. Other diseases that needed more of prevention, through a sanitary environment, than cure such as malaria, typhoid and dysentery among others, continued to be endemic indicating that modern sanitary measures introduced by the colonial administration had not been imbibed by the Delta peoples.

These lapses, notwithstanding, one can posit that by 1960, the colonial administration had laid a good foundation for modern medical and health services leaving much room for both qualitative and quantitative improvement and expansion.

CHAPTER SIX

CONCLUSION

The development of modern medicine in the Warri/Delta Province resulted from collaboration among governmental agencies (central, provincial, local and regional governments) on the one hand and governmental and non-governmental agencies (Christian missions, commerical companies, individuals and communities) on the other hand. The health ministry controlled all institutional medical and health services through authorising their establishment and supervising them regularly to ensure compliance with required standards. It also ensured that health services by various agencies complemented one another by fair spatial distribution. For example, after instituting medical and health facilities in the townships between 1906 and 1929, the central and provincial authorities encouraged the Christian missions and the NAs to initiate similar services in the rural areas from 1930.[1] Co-operation among various agencies also extended to the establishment of single institutions considered crucial for expanding health services and the control of endemic diseases.[2]

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1. Government launched NA Dispensaries in 1930 and gave grants to assist poor N.As. See NAI, Kwale Dist. 2 KNA 3 Vol. II: NA Dispensaries 1931-37, pp. 21, 103, 113 and 118. Also gave grants to Christian Missions as from 1929/30, see. Sydney Phillipson, *Report on Grants-in-Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria* (Appendix D), Lagos: Government Printer, 1949) p.55.

2. NAI, 26/2/14617 Vol. III: Annual Report, Benin Province, 1932, p.34; Volume X: Annual Report, Benin Province, 1934, p.5.

Unlike in many British African colonies and other Nigerian areas where non-governmental agencies first opened medical centres,[3] the colonial state pioneered and dominated institutional practices of modern medicine in the Warri Province between 1906 and 1929. This resulted from its desire to comply with the provisions of its ordinances, notably the Prisons Ordinance Number Nine of 1876, the Pilotage and Harbour Ordinance Number Three of 1878 and the Town, Police and Public Health Ordinance Number Ten of 1878. These ordinances stipulated that medical and health facilities should be instituted in prison yards, harbours and townships.[4] They led to the opening of African hospitals in the coastal towns of Sapele, Warri and Forcados in 1906, European hospitals in Sapele and Warri in 1906 and 1909 respectively and dispensaries in the other towns and district headquarters. The central and provincial authorities also instituted public health measures, including house to house inspections, inoculation against smallpox and mosquito control measures in these towns. Only emergency measures aimed at controlling the spread of epidemic diseases were extended to the rural communities within this period during serious out-breaks of diseases especially smallpox.[5] The establishment of these medical and health facilities for both European and African

3. A. Adeloye, *African Pioneers of Modern Medicine: Nigerian Doctors of the Nineteenth Century* (Ibadan University Press, 1985), pp.44-45; W.D. Foster, *The Early History of Scientific Medicine in Uganda* (Dar es Salaam: East African Literatures Bureau, 1974), pp.2-13.

4. *Laws of Colony of Lagos* Vol. I (London: Stevens and Sons, 1902) pp.192-213, 354-369, 383-389.

5. NAI, CSO 26/2/11857 Vol. VI: Annual Report, Warri Province, 1928, p.66; Vol. VII, Annual Report, Warri Province, 1929, pp.79-80.

communities, including non-government workers, evidently modifies the conclusion of J.C. Caldwell that colonial medical services served only the white communities until after the First World War.[6] Within this period discrimination only concerned the grant of free medical attention to government workers while others paid for their treatment. Even non-government workers who were certified paupers by competent authorities received free medical treatment from government health institutions.[7] Thus, modern medicine which primarily aimed at reducing the high mortality and mobidity rates of Europeans during the era of exploration in the nineteenth century, later extended to the Delta peoples.

After instituting modern medical practices in the towns the colonial state encouraged other agencies to initiate similar services in the rural communities. In 1930, it launched NA dispensaries in the country and gave financial assitance to poor NAs to establish dispensaries in their areas of authority. Between 1931 and 1944, the NAs in Warri Province opened seventeen dispensaries in rural communities.[8]

The provincial and central authorities also collaborated with the NAs in instituting public health measures in the rural areas within this period. In 1932, the central government gave grants for the construction of public latrines and

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6. J.C. Caldwell, "The Social Repercussions of Colonial Rule: Demographic Aspects, p.477.

7. Nigeria, Government Gazette No. 265, Rule No. 6 of 1906, Hospital Proclamation No. 7 of 1903, p.338.

8. NAI, CSO 26/2/11857 Vol. XVIII: Annual Report, Warri Province, 1941 Onwards (1946), p.9.

incinerators at Ashaka and Obiaruku markets and sinking wells at Obetim Kwale, Warri Prisons and Sapele.[9] The NAs maintained these latrines and wells established with grants from the central government. On the other hand the provincial authorities in conjuction with the NAs instituted measures for the control of the most common endemic diseases especially malaria, yaws and smallpox. House to house inspections and inoculation against smallpox extended to NA headquarters, public institutions and villages adjacent to them. Mosquito control measures were also introduced to these areas. Medical officers and dispensary attendants toured rural communities mainly for the treatment of yaws and other diseases.[10]

These initial medical and health services in the rural communities instituted by the central, provincial and local governments provide evidence to correct the conclusion of Dennis Itayvyar that "it was only after the 1950s that fortunate rural areas started to have dispensaries within a radius of 100 miles". According to him before the 1950s hospital and dispensary services were provided in urban and semi-urban centres such as Lagos, Enugu, Kano, Kaduna, Jos and towns as Makurdi and Sokoto.[11] Evidence from this study shows that by 1930 the different arms of government had developed consistent policies for the

9. NAI, Kwale Dist 1/141 Vol. III: Annual Report Aboh Division, 1935, p.28.

10. NAI, Kwale Dist 1/141, Vol. VI: Annual Report, Aboh Division, 1938, p.57.

11. Dennis A Itayvyar, "The Colonial Origins of Health Care Services: the Nigerian Example" in *The Political Economy of Health in Africa* eds. Toyin Falola and Dennis Itayvyar (Ohio: Ohio University Centre for International Studies, 1992), p.80.

expansion of medical and health services to rural communities and by 1944 had achieved some success.

The colonial government also gave financial assistance to the Christian missions to expand their medical and health services which mostly centred in the rural areas. Such grants encouraged the Niger Diocese of the Anglican communion with headquarters at Onitsha and medical headquarters at Iyienu hospital to extend its medical services to the Warri Province. Between 1930 and 1944 the CMS founded maternity homes and child welfare centres at Bethel, Ozoro, Ughelli, Enwe, Igbudu and Oleh towns. Impressed by the work of the CMS especially in maternal and childwelfare services, an area in which the NAs had made no attempt to provide services, the provincial authorities gave grants, which rose from five pounds in 1933 to fifty pounds in 1936, to the CMS to support their services.[12] Financial aid from the different arms of government enabled the CMS to expand its medical work including vocational training homes for girls on domestic economy and house management. The CMS also supported another group of girls who carried out campaigns on clean environment into rural communities through demonstrations on practical hygiene. These measures which aimed at health education and prevention of diseases provide us with evidence with which to correct the view of Itayvyar, that the missions merely mentioned preventive measures without according them priority in their medical

12. NAI, CSO 26/2/11857 Vol. XII: Annual Report Warri Province 1934, p.21; Vol. XIV: Annual Report Warri Province 1936/37, p.437.

and health activities.[13]

The successful institution of medical and health services in both urban and rural areas between 1906 and 1944 as well as the popularity of such services among the Delta peoples and other Nigerians encouraged the colonial state to undertake expansion of medical and health services in an unprecedented scale to satisfy agitations by the Nationalists for the expansion of health facilities. Within this period the number of Christians, government workers, pupils and students who mostly desired modern medicine had increased tremendously. Even the traditionalists who had started to accept the rationale of modern medicine because of its effectiveness in treating certain diseases also wanted more health facilities.

The Ten-Year Development Plan, the first of its kind, launched in 1945, set in motion intensified efforts to expand modern medicine to satisfy popular demand. The colonial administration jointly financed the plan with the British Labour Party government of Clement Atlee which abandoned the British traditional colonial policy of "self sufficiency" in executing social and economic development projects in the colonies in favour of government sponsored programmes as enunciated in its 1940 and 1945 Colonial Development Acts respectively. The Nigerian government augmented the British government's free grant of twenty-three million pounds with thirty-two million, out of which £8,323, 327 was designated for medical and health services in addition to £453,870 voted for leprosy control for the first five years. The scheme which the Director of Medical and Health Services, J.W.P. Harkness and his deputy, George Blyth Walker, drafted

13. Itayvyar, "The Colonial Origins of Health Care Services: the Nigerian Example:, p.69.

emphasised expansion of medical and health facilities in the urban as well as in the rural areas and the training of local personnel to manage them.[14]

The Ten-Year Plan recognised the expediency for co-operation among various agencies in the development of health facilities but it did not go far enough in the devolution of functions and finances to the various agencies. It concentrated the execution of most projects in the central authorities and this stalled the execution of most projects. In the Warri province for example, none of the following projects under the federal authorities was completed within the first phase: expansion of existing hospitals at Warri, Sapele and Forcados and founding a general hospital at Kwale and a Rural Health Centre at Ughelli; establishing a Mobile Field Unit and constructing urban and rural water projects. Except for the Warri hospital and the Warri Urban Water Scheme where work commenced by 1950 and the construction of wells, work did not start at all in all the other projects. Although the government explained its failure to execute projects in the first phase of the Ten-Year Plan in terms of lack of material and finance,[15] it could also be explained in terms of over concentration of the execution of projects in the federal authorities.

The provision for Mobile Field Units which were meant to deal promptly with out-breaks of endemic and epidemic diseases in rural as well as urban

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14. *Ten Year Plan of Development Nigeria*, pp.1, 67-72, 80-82.

15. NAI War prof, WP 235/1 Vol. IV: Annual Report, Warri Province, 1950, p.95; Annual Report, Development and Welfare Scheme 1950-51 Appendices 1 & J.

communities and the provision for urban and rural water schemes meant to facilitate clean environment counter Itayvyar's conclusion that the plan hardly voted any money for preventive health services.[16] Even before the plan, the health ministry had always provided separate budgets for medical and sanitary services annually while the NAs had their own estimates for medical and sanitary services in the rural areas.[17]

The Ten-Year Plan made provision for grants amounting to ten percent of the annual expenditure of the NAs on medical and health services to assist them in their health services. Although this grant kept the spirit of collaboration alive, it did not give the NAs enough encouragement to undertake meaningful expansion of facilities as evisaged in the plan within this period. Only two NAs could establish new dispensaries while all the NAs had difficulties in maintaining their old dispensaries. None could establish a maternity home.

The Ten-Year Plan also recognised the importance of assisting the missions in the expansion of their medical acitivities but did not give them enough encouragement within this period. Except for leprosy control services the plan did not provide for a regular system of grants-in-aid to the missions for their other medical activities initially. The government, however, indicated its willingness to give capital grants to the missions later. Only the Eku Baptist Hospital benefitted from the government's capital grant in the Warri Province. It received a grant of

16. Itayvyar, "The Colonial Origins of Health Care Services: the Nigerian Example", p.78.

17. See for example, Blue Books, Nigeria 1920-1929, Sections two.

£750 from the government for the purchase of an ambullance.[18] The missions continued to maintain their existing hospitals and open new ones without government support. The CMS opened a new maternity home at Abbi and a dispensary at Umuolu in 1947,[19] while the RCM opened maternity homes at Sapele and Obiaruku.[20] The most spectacular missionary activity was the opening of a thirty-two bed, well equipped hospital by the American Baptist mission at Eku in 1950. It started in 1945 as a dispensary.[21]

Other non-governmental agencies carried out their medical activities without government's financial assistance. To satisfy the demand for modern medical facilities, communities started to establish medical institutions with their own funds. The Abraka community for example, opened a maternity home, the Immaculate Conception Maternity, in 1946. In recognition of the importance of efficient administration, the community handed the centre over to the RCM for management.[22] The commerical companies operating in the province also started

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18. NAI, Ughel Dist. 1/289, p.45. Memo from the Resident to Medical Director Eku Hospital 16-9-49, p.46, Medical Director Eku Hospital to SDO Urhobo Div. 12-9-49.

19. NAI, MH/Fed/1/1/7359F: Annual Medical Report, Nigeria 1947, p.5[E].

20. NAI, MH/Fed/1/1/6662[F]: Annual Medical Report, Nigeria 1946, p.41[A&B].

21. NAI, CSO, 26/2/11857 Vol. XVIII: Annual Report, Warri Province, 1941 onwards (1950), p.41; "History of Eku Baptist Hospital, paper presented at its 40th Anniversary by the Organising Committee", 1990, pp.1-2.

22. Annual Medical Report, Nigeria 1946, p.41[A&B].

to provide modern medical services to their workers and their relatives to reduce the rate of absenteeism on health grounds. The Palmol Company Sapele opened a maternity (1946), and a dispensary (1947), at the Sapele Rubber Estate, a hospital and maternity home (1949), at the Cowan Estate Ajagbodudu and a dispensary at Ologbo in 1950.[23]

The colonial government realised its failure to execute projects in the first phase of the Ten-Year Plan and decided to revise the whole plan at the end of five years inorder to introduce new ideas and projects.[24] It allowed the regions that emerged from the 1946 constitution to draw and implement the Revised Plan. The new plan introduced new measures which included financial assitance to Christian missions and private individuals embarking on medical projects, establishing joint mission and government hospitals and a new system of grants-in-aid to the NAs.[25] The Western regional government introduced its own health policy in 1952 to complement the National Plan. It introduced free medical treatment for school children and grants to the NAs for the expansion of facilities.[26]

Decentralisation of functions facilitated the execution of projects in the Revised Plan. The regions successfully executed the projects with funds provided

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23. NAI, MH/Fed/1/1/9128[L]: Annual Medical Report, Nigeria 1949, Private Medical Report, Nigeria 1949, Private Medical Activities, p.9.

24. *Revised Plan of Development, Nigeria*, p.4.

25. Ibid, p.24.

26. *Public Health Policy for the Western Region Nigeria* (Ibadan: Government Printer, 1952), pp.1-7.

by the federal government. In the Delta Province, for example, the Western regional government executed all projects formerly under the central authorities mentioned earlier.[27] Lapses occured when funds could not complete projects as in the rural water scheme project where the number of wells envisaged could not be sunk for lack of funds.[28] With the new system of grants from the Development Funds and the block grants for four dispensaries and four maternity homes for each division, from the Western regional government, the NAs also achieved a very rapid expansion of dispensaries and maternity homes as well as training personnel to manage them. With the involvement of Delta peoples in the health committees which effected policy implementation within this period, health facilities were equitably distributed among the clans. By 1960 each clan had at least one modern government medical institution established in its area.[29] Similar successes were also achieved in the expansion of sanitary measures with the new method of stationing sanitary officers in specific clans where they administered vaccinations

27. NAI, CSO 26/2/11857 S.I.: Annual Report, Delta Province, 1952, p.57; MH/Fed/1/1/12616[C]: Annual Medical Report, Western Region, 1954, pp.3 and 34; NAI War Prof 2, 235/1/Vol. IX: Annual Report, Delta Province, 1955, pp.17-79; NAI, War Prof 2, 235/1 Vol. VII: Annual Report, Delta Province 1953, enclosure 75, p.13; NAI, Ijaw (W) 4, W1 335/3: Annual Report, Western Ijaw, 1955, p.40.

28. NAI, Ughel Dist. 1/825/2 p.83: Ag. Chief Sec. to Govt. to Sec. WP 15-6-49; pp.87-88: Memo, CSG to Sec. Western Provinces 15-7-49.

29. Annual Report, Delta Province, 1952, Enclosure 14, p.8; Annual Report, Delta Province, 1953, Enclosure 77pp. 19 and 20, Enclosure 14, p.8; Enclosure 75pp.10-11, Enclosure, 88p.21; Annual Report, Delta Province 1955, p.42; War Prof 2, 235/1 Vol. VIII: Annual Report, Delta Province, 1954, p.7.

and house to house inspections. These measures reached all rural communities within this period.[30]

Although the Christian missions in the Delta Province did not benefit from the grants provided by the Revised Plan because the Eku Baptist Mission to which the government offered a grant rejected it, some received assistance locally. The CMS received financial help from the Kwale NA and the provincial authorities for the reconstruction of its maternity and dispensary at Umuolu while the community provided voluntary labour. On the other hand, the management of the Eku Baptist hospital accepted financial contribution by the community to compensate land donors for their economic trees while it financed its expansion programme.[31] By 1957, the number of beds had increased from thirty-two in 1950 to seventy-three. It also started a training programme for technicians and nurses. Only the RCM embarked on new projects without financial assistance from the governments. It opened an eight bed maternity in 1952 at Umutu and another at Ozoro in 1958.[32]

There is no evidence that the doctors, midwives and nurses on private practice in the Delta Province received any of the various grants provided for private practitioners by the Revised Plan because they belonged to the category of medical personnel who protested against the ban on their private practice while in

30. Annual Report, Delta Province, 1955, p.42; Interview, Agbaza Ighe, Aged 64, Politician/Business man at Ozoro, 2 December, 1991.

31. "History of Eku Baptist Mission", p.2; NAI, War Prof 1 WP 206/2, p.34: Minutes of Council Meeting Aboh NA 28-3-52.

32. Ibid. p.39: Memo, Medical Dept. Benin to Resident Delta Province; p.40: Resident Delta Province to DO Aboh Div. 18-12-52.

government service by resigning their appointments and founding their private medical centres. Between 1951 and 1960, the activities of this category of private practitioners such as Dr. Folarin Ogunro, Dr. F.O. Esiri, Mrs. P.R. Knox, Mrs. O. Nelson Williams, Mrs. G.E. Adigwe, Chief Florence Elemi-Rewane who founded hosptials, maternity homes and clinics fostered the expansion of medical facilities suplementing government medical services.[33] Their services also met with popular acceptance by the Delta peoples.[34]

Only the commercial companies had no provision, in the Revised Plan, for financial encouragement for their medical work. Yet they played an important role in the expansion of modern medical facilities within this period. The UAC founded a maternity hosptial at Sapele Rubber Estate (1952), two dispensaries at its Timber Estate Burutu (l953), a well equipped hospital for its Niger River Transport Division, Burutu (1953), a dispensary at Koko for its Bulk Oil Division (1954), and a hosptial at its African Timber and Plywood factory at Agbaje Sapele in 1954 to satisfy the medical needs of their workers, their relatives and others who were prepared to pay for their treatment.[35]

As profit seeking business men and women, the patent medicine dealers

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33. NAI, MH/Fed/ 1/1/11841[C]: Annual Medical Report, Private Medical Activities, 1951/52, p.3; Annual Medical Report, 1952/1953, p.5; Interview, Florence Elemi-Rewane, Aged 65, Retired Nurse and Midwife in Private Practice, Warri, 1 May, 1995.

34. Interview, Rewane.

35. NAI, MH/Fed/1/1/12010J: Annual Medical Report, Nigeria, 1952/53, p.5; Annual Medical Report, Western Region, 1954, pp.21-22; Annual Report, Delta Province, 1954, Enclosure 2, p.28.

continued to expand their services because of the great demand for them. By 1960, medicine stores had sprung up in such rural areas and nascent towns as Abraka, Orogun, Ashaka, Obiaruku, Eku, Kokori-in-land, Okpara-water side, Ozoro, Ivrogho, Orho-Agbarho and Okwuagbe-water-side.[36] Even in hospital towns and villages the patent medicine dealers competed favourably with government institutions because of the obvious advantages of their services which included quicker and cheaper services as well as establishing intimacy with their customers among others. They also indulged in administering illegal injections because of the high demand for them due to their effectiveness in treating yaws and smallpox. Most dispensers were not authorised to give injections, hence the people patronised patent medicine dealers. In fact, they extended modern medicine to the remotest parts of the province. The great demand for their services despite unfortunate incidents such as deaths and deformity,[37] resulting from them, indicates that although hospitals, dispensaries and maternity homes had been established in many parts of the province, they did not satisfy the health needs of the people especially as dispensary services lapsed most of the time.

The acceptance of modern medicine by the Delta peoples increased with the expansion of medical facilities and the educated elite over time. Evidence from the African hospitals opened in 1906 reveal a very low initial acceptance, reflecting

36. NAI, War Prof 1, WP 370: Permit Under Pharmacy Ordinance 1936, p.78: Memo, CSG to DMS 16-6-46; p.282: List of Registered Chemists and Druggists

37. Interview, Agbaza Ighe.

the low number of Christians, public servants, pupils and other Western educated citizens who pioneered the acceptance of modern medicine from its inception.[38] They campaigned for its acceptance by other Delta people and the expansion of health facilities. By the end of 1929 vaccination had been generally accepted in the towns where the facilities were available because its efficacy in controlling small-pox had been demonstrated. Only very few cases and deaths occured in these towns in 1929 while cases and deaths in the rural areas where the facilities were not available remained very high.[39]

Between 1930 and 1944, the educated citizens and Christians had spread into the rural areas in large numbers as school and Church teachers, local government and company workers, pupils and students. Their campaigns and propaganda supplemented enlightenment campaigns by government agents and enhanced the acceptance of modern medicine by the traditionalists who had also started to benefit from modern medical services. The dispensaries and maternity homes established by the CMS and the NAs within this period recorded very high attendance figures.[40] The fall in attendance in NA dispensaries in 1936 resulted from the introduction of dispensary fees by the provincial authorities in that year.

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38. See for example, *Blue Book*, Southern Nigeria, 1909, pp. DD. 19, 25, 27; 1910, pp. DD. 14, 18, 20; 1911, pp. DD. 18, 23, 26, *Blue Books* , Nigeria, 1928, Section 26, p.598.

39. Annual Report, Warri Province, 1929, pp.79-80.

40. See attendances at Orerokpe and Ughara Dispensaries in 1931, NAI, 26/2/11857 Vol. IX: Annual Report, Warri Province, 1931, p.38 and the CMS dispensary Bethel in 1930, NAI, CSO 26/2/11857 Vol. VIII: Annual Report, Warri Province, 1930, pp.317-318.

Some patients later complained of the hostile attitude of some health workers while others complained of the ineffectiveness of tablets given to them instead of injections they preferred. They therefore started to seek alternative treatment from hospitals, patent medicine dealers and traditional medicine men and women.[41] Dispensary services in the Ijo division, however, continued to be popular throughout the period mainly because the dispensary attendants in that division were authorised by the Medical Department to administer injections for the treament of yaws, leprosy and dysentery because of the high infestation of the diseases in the division among other reasons.[42]

During the decolonisation period (1945-60) Westerm ideas had further expanded into the remotest areas of the province, through expansion of schools, churches, public servants and other educated citizens. Health and medical institutions had also begun to be associated with modernisation, development and progress. Demands for them had started to feature prominently in interactions with political officers and in newspapers.[43] At this stage the acceptance of modern

41. NAI, Kwale Dist. 1, 141 Vol. X: Annual Report Aboh Division 1942, pp.29 & 131; Kwale Dist. 1, 141 Vol. V: Annual Report, Aboh Division 1936, pp. 18 and 23.

42. Annual Report, Warri Province 1941 Onwards (1942), p.15; (1944), p.6; (1946), p.9.

43. See for example, T.T. Uchendu, "More Hospitals for Warri Provinces" *Southern Nigerian Defender*, 7 March 1944, p.1; J.E. Ogboru, "Two or three more Hospitals for Warri Province", *Southern Nigerian Defender*, 3 April 1944, p.2; "Sapele General Hospital" *Nigerian Star*, 13 October, 1951, p.4; Ukwuani Improvement Union, "Social Facilities" *Nigeria Standard*, 9 February 1951, pp.1-2.

medicine had become general especially for the cure of those diseases it had proved more efficacious than indigenous medicine as in the control of yaws, leprosy, smallpox and chicken pox. Modern medicine had also become very popular for such processes as surgical operation, blood transfusion, X-rays and injections.[44] In fact, by 1960, obtaining treatment in modern medical institutions had become very fashionable because the educated class blamed most deaths on non-attendance to a hospital, dispensary or maternity home for treatment.

The Delta peoples did not, however, put aside indigenous medicine because they embraced modern medicine. Traditional healers continued to treat diseases which the people considered them more competent in handling. They believed that asthma, snake bite, epilepsy, insanity, stroke, diabetes, fractures and paralysis responded better to indigenous methods.[45] Official reports acknowledged the peoples syncretic approach to healing. In 1951, the Resident, John Harold Beeley, observed that "native medicine still has a strong pull"[46] He echoed the views of his predecessors in the 1930s. Like other Nigerians the Delta peoples saw modern

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44. Interview, Umukoro Ighomor, Aged 76, A Herbalist, Ozoro, 2 December, 1991.

45. John Ubrurhe, "Urhobo Traditional Medicine", Department of Religious Studies, University of Nigeria, Nsukka, Ph.D., 1993, p.317; John Chikogu, "Patterns of Utilisation of Health Care Services in Rural Communities, A case studyof Amai Town", Department of Physical and Health Education, University of Ibadan, M.ED., 1984, pp.80-81; Interviews, Umukoro; John Eyekpeha, Aged 70, Herbalist, Abraka, 22 November 1990.

46. NAI, CSO 26/2/11857 Vol. XVIII: Annual Report, Warri Province, 1951, p.22.

medicine as an alternative method of treating diseases. At the out-break of any diseases, the sick or their relatives chose the system which they considered more effective. By 1960 they had made a clear distinction between illnesses to which modern medicine should be applied and those for which indigenous medicine should be used as we have earlier shown. Cases taken to hospitals could be withdrawn on discovering that indigenous healers could perform better. For example, the Medical Officer of Forcados, Dr. B.J. Ikpeme, discovered in 1950 that "mental cases have been taken away by their relatives".[47] That practice has continued till today and accounts partly for the popular call for the development of indigenous medicine inorder to treat cases it is considered more efficient than modern medicine.

Two other reasons reinforce the preference for traditional medicine for the treatment of some diseases. First, the belief that modern medicine is ineffective in treating diseases believed to have emanated from metaphysical forces: witches, wizards, ethical divinities, ancestors, and evil spirits has persisted till date despite Christianity.[48] We showed in chapter one that such diseases call for diagnosis by diviners and appeasement of the purportedly offended spiritual forces through sacrifices by appropriate priests or priestesses. Only traditional medicine has such processes. Second, the belief in the ability of traditional medicine to ward off,

47. Annual Report, Warri Province, 1950, Enclosure p.90, p.11.

48. Interview, David Enaworu, Aged 55, Herbalist and Witch Doctor, Abraka but hails from Okpara in Agbon clan, 15 November, 1990.

neutralise, or offer protection from spiritual and even physical attacks as well as solve social and economic problems such as promotion of business, securing new jobs and attracting favour from others has also persisted and has recommended indigenous medicine to most Delta people.

We must add that colonial medical policy which allowed the two systems of medicine, modern and traditional, to be practised fostered the development of medical pluralism. Although the colonial government did not favour the practice of traditional medicine it legalised its practice on condition that the practitioners did not engage in acts that were "dangerous to life".[49] An attempt by the colonial administration to control traditional medical practice by introducing a register for the practitioners under the Registration of Business Name Ordinance Number 5 of 1926 eventually resulted in boosting their business. Although the Registration of Business Name was a very unpopular Ordinance which the rural communities resisted, the traditional healers responded to it spontaneously and when they acquired it, designated it a licence showing that they had been tested and found competent to treat the number of diseases innumerated in their certificates. By the time government agencies started discrediting the certificates, arguing that they were no licences, but only meant that no other person should designate his business by that name, the practitioners had already popularised themselves as accredited and lincenced traditional healers, formed unions recognised by the government to promote their interests and aspirations. They came out from colonial rule stronger, more popular and confident than at the beginning of the

49. NAI, Government Gazette May-December 1906, Vol. 1, p.101.

colonial administration having formed organisations uniting them at the clan, divisional and provincial levels.[50]

The post-colonial Nationalist governments of the country inherited the colonial medical policies as they affected the practice of traditional medicine with the practitioners receiving genuine encouragement from government and scholars following the current of cultural nationalism sweeping the whole of the African continent. Traditional medicine constitutes one of the aspects of the African culture adjudged worthy of preservation in view of its relevance in health care delivery and the inability of governments to cope with the adequate supply of modern medical services. Recently, health commissioners started inaugurating state branches of the association of traditional healers. The Bendel state, for example, inaugurated the Bendel United Association of Traditional Doctors in March 1979 and by 1981 the association had had a numerical strength of 37,684 registered traditional healers.[51] The State comprised the colonial Benin and Delta Provinces. Scholars have also, in recent times, engaged in spirited debates and prescriptions on why and how traditional medicine should be integrated into

50. NAI, War Prof 1, WP 471, p. 50: Letter from Sapele Branch of Native Doctors' Association through the DO Sapele to Warri Branch, 25-7-49.

51. O.Y. Oyeneye and I.O. Orubuloye, *Some Aspects of Traditional Medicine in Bendel State of Nigeria: An exploratory Study* (Ibadan, NISER, 1985), pp. 15 and 21.

modern medical programmes.[52] The contribution of this study to that debate is that the two systems should be developed independently to play complementary roles, as they have been playing in satisfying the health needs of the people. Referrals could be made if one system acknowledges the superiority of the other in the management of particular diseases. Fear of subordination and of being compelled to divulge information about the time hallowed medicinal expertise of the indigenous healers will obviously make outright integration difficult and unrewarding if they decide to have reservations.[53] Feierman has shown that medical pluralism has become a common feature in African societies, already studied, since the introduction of modern medicine.[54] The inability of governments to supply modern medical services adequately and the preference for traditional medicine for the handling of some medical and health problems have made it imperative to develop traditional medicine.

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52. See for example, Adeniyi Jones, "The Roles of the Hospital in the Public Health Programme with particular reference to Developing Countries" *WAMJ.* New Series, Vol. VII, No. 1, 1958, pp.76-78; A.E. Erinosho and Ayorinde, *Traditional Medicine in Nigeria: A Study Prepared for the Federal Ministry of Health* (Lagos: Govt. Printer, 1985), pp.8-10; Zacchaeus A. Ademuwagun, "Problems and Prospects of Legitimizing and Integrating Aspects of Traditional Health Care Systems and Methods with Modern Medical Therapy: The Igbo-Ora Experience" in *African Therapeutic Systems* (eds), Z.A. Ademuwagun, J.A. Ayoade, I.E. Harrison, and D.M. Warren (Waltham Massachusetts: Cross Road Press, 1979), pp.162-164; Oyeneye and Orubuloye, *Some Aspects of Traditional Medicine in Bendel State*, pp.31-32.

53. Interviews, Abamba; Udi.

54. Feierman, "Struggles for Control", pp.74-80.

The fact that the two systems of medicine, indigenous and modern, have served the health needs of the Delta peoples, as other Nigerians, since the institution of modern medicine validates two different views on the impact of colonialism in Africa. One is J.F.Ade.Ajayi's view that colonialism represented an episode in the history of Africa because it did not cause any break in the continuity of old practices.[55] As far as traditional medicine is concerned there has been no break in the continuity. If the aspirations of the cultural nationalists come through there may be no break in the future. We can only add that as the traditional system continues to be relevant, the modern system has also come to stay and has succeeded in overshadowing it. In that sense the view of R.Davis Hunt that the colonial era represented a period when Africa became linked to global civilisation is also apt in view of the prominent role of modern institutions, including health services, over indigenous ones. According to him modern civilization, originating from Western Europe and America spread to other peoples of the world during their colonial experience.[56] As far as medical and health services are concerned the two views are apt and have manifested in medical pluralism practised in Africa and other parts of the world where modern medicine has been introduced.

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55. J.F. Ade. Ajayi and M. Crowder, "West Africa 1919-1939: the colonial situation" in *History of West Africa Vol. II*, 2nd Edition, eds. J.F.A. Ajayi and M. Crowder (Hongkong: Longman, 1987), p.602.

56. R. Hunt Davis, Interpreting the Colonial Period in African History" *African Affairs*, 72, 1973, pp383-400.

Appendix

List of Medical Institutions in Warri/Delta Province 1906-1960

Government Hospitals and Dispensaries

SN	Institution	Year	Remark
1	Sapele African Hospital	1906	
2	Sapele European Hospital	1906	Closed down 1925
3	Forcados African Hospital	1906	
4	Forcados Quarantine Station	1906	
5	Warri African Hospital	1906	
6	Warri European Hospital	1909	
7	Warri Infectious Disease Hospital	1919	
8	Sapele Infectious Disease Hospital	1919	
9	Ossiomo Leper Settlement	1933	Situated in Benin Province
10	Ughelli Health Centre (Hospital)	1953	but also served Warri "
11	Obetim Kwale General Hospital	1956	

Dispensaries

1	Obetim Kwale Dispensary	1906
2	Burutu Dispensary	1925

Native Administration Institutions
Aboh/Kwale Division

Dispensaries

1	Abbi	1931
2	Utagbauno	1933
3	Aboh	1934
4	Ase	1952
5	Ogume	1952
6	Obiaruku	1955
7	Iselegu	1956
8	Okpai	1956
9	Abedei	1956
10	Amai	1956

Maternity Homes

1	Ashaka	1954
2	Ogume	1954
3	Ase	1956
4	Aboh	1956
5	Abedei	1956
6	Onicha	1956

Native Administration Institutions
Aboh/Kwale Division (cont'd)
Leper Segregation Villages

1	Umutu	1942	Clinic only
2	Utagbauno	1946	
3	Ukwage	1947	
4	Aniator	1947	
5	Ibrede	1948	
6	Ossissa	1949	
7	Igbruku	1949	
8	Umuebu	1956	
9	Eberedemi	1956	
10	Emu	1956	

Ijo Division
Dispensaries

1	Ramos River	1932
2	Aleibiri	1933
3	Akugbeme	1934
4	Ogoibiri	1935
5	Patani	1936
6	Sagbama	1937
7	Ojobo	1953
8	Burutu	1956
9	Nun River	1956
10	Okrika	1956

Maternity Homes

1	Bomadi	1954
2	Burutu	1956
3	Patani	1956
4	Ojobo	1956
5	Okrika	1956

Leper Segregation Villages

1	Ayakoroma	1954
2	Jeddo	1955

Urhobo Division
Dispensaries

1	Ughara	1931
2	Orerokpe	1931
3	Okpara	1931
4	Abraka	1937
5	Ughelli	1938

	Dispensaries Urhobo Division (cont'd)		
6	Owe	1950	
7	Oleh	1950	
8	Usoro	1950	
9	Jesse	1950	
10	Udu	1950	
11	Tori	1950	
12	Ewu	1952	
13	Owahwa	1953	
14	Ovbakwa	1953	
15	Igbide	1954	
16	Odjorovbe	1956	
17	Ivorogbo	1956	
18	Gbaragolo	1956	
19	Orogun	1956	
20	Agbassah	1956	
21	Adadhe	1956	
22	Olomoro	1957	
23	Aviara	1957	
24	Agbasa Ogelle	1957	
25	Agbudu	1957	
26	Uwerun	1957	
27	Ovbodokpokpor	1957	
	<u>Maternity Homes</u>		
1	Ughelli	1944	Transferred to Ewu 1952
2	Orerokpe	1951	
3	Ewu	1952	
4	Edjorovbe	1955	
5	Emevor	1955	
6	Oginigbo-Jeremi	1955	
7	Agbarho	1955	
8	Okpara-in-land	1956	
9	Jesse	1956	
10	Tori	1956	
11	Otor Udu	1956	
	<u>Leper Segregation Villages</u>		
1	Abraka	1952	
2	Eku	1952	
3	Orogun	1956	
4	Agbadu	1956	

	Leper Segregation Villages Orhobo Division (cont'd)		
5	Agbarho	1956	
6	Ewu	1957	
7	Usere	1957	
8	Illu	1957	
9	Okpe	1957	
10	Okpolo (Enwe)	1957	
11	Agbassah	1957	
12	Jeremi	1957	
13	Olomoro	1957	
14	Ughotor	1957	
15	Iyede	1957	
16	Emevor	1957	

Warri Division

Dispensaries

1	Benin River (Jakpa)	1944	
2	Koko	1953	
3	Gboromoda	1953	
4	Ubefan	1954	
5	Ogidigben	1954	
6	Ode Itsekiri	1956	
7	Jelu	1956	
8	Ibegborodo	1956	
9	Opuma	1956	

Maternity Homes

1	Ogbombiri	1956	
2	Saba	1956	
3	Beter	1956	
4	Gborodo	1956	

Mission Institutions

Church Missionary Society (CMS)

Dispensaries

1	Bethel	1930	Transferred to Oleh 1941
2	Uwerun	1933	
3	Ozoro	1933	
4	Ughelli	1933	
5	Enwe	1933	
6	Oleh	1941	
7	Umuolu	1947	

Mission Institutions (CMS) (cont'd)

	Maternity Homes		
1	Bethel	1930	Transferred to Oleh 1939
2	Ughelli	1933	
3	Igbudu	1939	
4	Oleh	1939	
5	Umuolu	1944	
6	Abbi	1947	

Baptist Mission

1	Eku Dispensary	1945
2	Eku Maternity Home	1945
3	Eku Baptist Hospital	1950

Roman Catholic Mission (RCM)

	Maternity Homes	
1	Sapele (St. Elizabeth)	1946
2	Obiaruku (Our Lady of Lourdes	1946
3	Umutu	1952
4	Ozoro	1958

Nigerian Gospel Mission

	Dispensary	
1	Sapele	1947

Private Institutions (Commercial Companies Hospitals)

	Location	Company	Year
1	Ajagbodudu	Palmol	1949
2	Burutu	UAC	1953
3	Agbaje Sapele	UAC	1954
	Dispensaries		
1	Burutu	UAC	1944
2	Sapele	Palmol	1947
3	Kwale	Nig. Hardwood	1949
4	Tolele	" "	1949
5	Ologbo	Palmol	1950
6	Sapele	UAC	1950
7	Koko	UAC	1954

Private Institutions (Commercial Companies (cont'd)

Maternity Homes

1	Sapele	Palmol	1946
2	Ajagbodudu	Palmol	1947
3	Sapele	UAC	1952

Private Institutions (Individuals)

Hospitals

	Location	Proprietor	Designation	Year	
1	Sapele	Dr. F.Ogunro	Eastern Drugs Depot	1951	
2	Warri	Dr. F.O. Esiri	Esiri Infirmary	1951	

Maternity Homes

1	Warri	Mrs. P.R. Knox	Blissful Maternity	1951	
2	Warri	Mrs. O. Nelson Williams	Maternity Clinic	1952	
3	Umutu	Mrs. G.E. Adigwe	Adigwe Maternity	1952	
4	Sapele	Mrs. G.E. Adigwe	"	1955	
5	Warri	Mrs. Florence Elemi Rewane	Numa Clinic	1960	

Community Institutions

1	Oria Abraka	Oria Abraka	Immaculate Conception	1946	Was managed by the RCM.

Source: Compiled by the Author from the Annual Reports on Warri\Delta Province 1906-1960, Department of Medical and Sanitary Services, 1906-1960 and Western Region 1953-1960.

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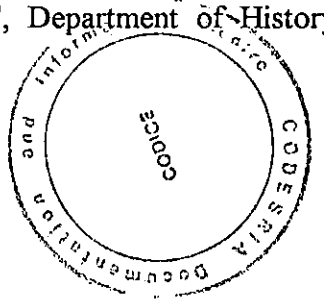

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