



Research Article

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Development of Health Education in the Context of Preventive Medicine in Western Nigeria, 1900-1945

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ABSTRACT

This study examines the institution and development of health education as a major component of the preventive healthcare policies of the colonial authorities in Western Nigeria from 1900 to 1945. It presents a historical perspective that reveals the foundation laid for related issues such as the teaching of hygiene in schools, health propaganda, antenatal lessons, public lectures, poster presentations and pamphleteering before the emergence of the World Health Organisation. Thus the study falls within the domain of the social history of medicine, a relatively neglected area in historical studies in Nigeria. Since it has not been a popular theme among historians, there is a dearth of literature on the subject. This accounts for the extensive reliance on primary materials obtained from the national archives, Ibadan and some oral interviews for information. Some secondary materials were also consulted. The data obtained were

subjected to historical analysis. The study concludes that health education fostered a new orientation in healthcare modalities and facilitated the development of scientific medicine in colonial Western Nigeria. It underscores the need to explore other neglected themes in the medical history of the area.

Keywords: *Health education, Propaganda, Hygiene, Colonial Rule, Western Nigeria*

1. INTRODUCTION

This study focuses on the development and utilisation of health education in preventive healthcare by the erstwhile colonial authorities in Western Nigeria from 1900 to 1945. The area was initially constituted into the Western and Central provinces in 1906, but was recaptured as a unit of administration in 1939 – the Western Group of Provinces. By 1939, the area was redesignated as the Western Region. This administrative history ensured that the communities in the region were exposed to similar preventive healthcare policies promulgated by the colonial authorities. In contemporary Nigeria, Western Nigeria as conceived in this study, covers eight contiguously located states in the South-west – Lagos, Oyo, Ogun, Ekiti, Osun, Ondo states inhabited mostly by the Yoruba people and Edo and Delta states in the South-South inhabited mostly by the Edo, Anioma and Ijaw people. The foundation for modern preventive healthcare, including health education in the area, was laid within the period under consideration as an integral part of the preventive healthcare policies of the Nigerian colonial state.

Despite the recourse to ordinances, rules and orders, the health department in colonial Western Nigeria recognized and treated health education as a core component of preventive healthcare. Accordingly, they initiated training and propaganda schemes to sensitise the people and shore up awareness about the prevalent diseases in the society and how to prevent them. At the point of British incursion, Western Nigerian communities only brought cultural paradigms, which were not rooted in scientific medicine, to bear on their medical practices. Therefore, taboos, divination, magic and medicine overlapped. Thus, medicine and



extraneous cultural variables was difficult to delineate and extricate from one another. Health education was aimed at discarding this heritage to give the people a new scientific orientation. This involved programmes that were geared towards creating new attitudes and advancing the people's knowledge about germs and the life circle of preventable contagious and infectious diseases.

Ipsa facto, health education became a formal enterprise into which material resources and men were deployed. The government believed that the quality of health education and the response of the natives to preventive healthcare policies directly correlated, and invariably affected the quality of human resources. The task of creating the right attitude was formidable. A comprehensive scheme, involving both conventional and unconventional instructional methods had to be created. The former encapsulated the introduction of hygiene into school curriculum, public lectures, pamphleteering and the training of sanitary inspectors. The unconventional approach involved the use of cinema and baby shows, for instance.

2. THE TEACHING OF HYGIENE

The decision to adopt the teaching of hygiene as a policy emanated from the Board of Education, based on the recommendation and a scheme prepared by Henry Strachan. The scheme was formally adopted on February 2, 1902. It incorporated a syllabus for elementary schools and a course of lecture to be delivered to school teachers, nurses and the public. Going by the policy, teachers were required to present themselves for examination to obtain sanitation certificate based on the Principal Medical Officer's lectures⁶⁸. The first two of such examinations were held on third and fourth of January 1902 by H. Strachan and Dr Hopkings respectively. On both days, a total of thirteen teachers obtained first class certificates while five obtained second class certificate out of a total of forty-nine successful candidates⁶⁹. This class of successful teachers became the seminal unit that fecundated the teaching of hygiene in elementary and grammar schools. The first schools to

⁶⁸ National Archives, Ibadan (NAI). Special Report on the Teaching of Sanitation: Annual Report. 1902 : 95

⁶⁹ NAI. Special Report on the Teaching of Sanitation: Annual Report. 1902 : 95



benefit in \western Nigeria were Anglican Grammar School, Lagos, and five elementary schools – Arolaya, Enu Owa, Christ Church, St. Peters and Jehovah Shallone Schools. Together they presented a total of 388 candidates of which 228 passed. Twenty pounds was awarded as special prize to the student who proved most proficient in the subject of sanitation⁷⁰. The scheme was soon extended to schools in the major towns of Ibadan, Abeokuta, Benin, Warri and Sapele. The curriculum captured the causes, transmission and prevention of diseases through environmental and water hygiene.

Public lectures on sanitation were also initiated as early as October 1902. The first, as stated in the Lagos Annual Report, was delivered by Orisadipe Obasa, drawing largely from Strachan’s lecture notes. He adopted a very civil approach that reflected his respect for traditional institutions as a Yoruba man. He sought and obtained permission to lecture the Alake-in-council, persuading them to embrace Western scientific ideas about preventive healthcare. Similarly he delivered public lectures at Enuwa, Ipapo, Shaki, Ibadan, Abeokuta, Badagry and Kishi⁷¹.

The services of Native Medical Officers like Orisadipe Obasa were not available in the Benin, Warri, and Asaba axis, until the late 1940s. Therefore schools, sanitary officers and vaccinators were the earliest propagandists who worked in tandem with the health authorities to spread the knowledge of hygiene. By 1925, every government assisted school had a calibrated course of instruction suitable for the various classes in primary and secondary schools, drawn from the Education Code for the guidance of teachers⁷². Students in training colleges and teachers attending evening classes or vocation classes also received courses of lectures in hygiene. Also, “inspection by sanitary inspectors and medical officers ... [had] an educative influence amongst adults”⁷³.

A scheme drawn up by the colonial authorities for preventive medicine and hygiene in 1925 stressed the role of the Medical Officer Health. He was charged with the duty of giving “instruction on special

⁷⁰ NAI. Special Report on the Teaching of Sanitation: Annual Report. 1902 : 96

⁷¹ NAI. Special Report on the Teaching of Sanitation: Annual Report. 1902 : 95

⁷² NAI. Annual Report. 1925 : 28

⁷³ NAI. Annual Report. 1925 : 29

diseases such as waterborne diseases” and “lecturing... children in schools whether government or mission on hygiene and sanitation”⁷⁴. He carried out regular inspection of all schools and conducted periodic examinations. It was his responsibility to inspect the area to which he is appointed and to abate nuisances. By 1924, there was only one qualified Medical Officer of Health for the whole of Nigeria. More were subsequently appointed based on a proposal made by the Director of Medical and sanitary Services, Alexander which arranged Lagos and the Western Group of Provinces into three administrative units, each placed under the charge of one or more Medical Officer of Health (MOH) as shown in the table below:

Table 1: Scheme for the Deployment of Medical Officers of Health (MOH) in Western Nigeria

No of Medical Officer of Health	Provinces	Area in Square Miles of Population	Total Square Miles to be Served	Population of Provinces	Total Population to be Served by M.O.H
1	Oyo, Abeokuta, Ijebu-Ode	14,381 4,338 2,432	21,051	1,085,498 319,349 182,532	1,587,379
2	Benin Warri Ondo	7,489 10,260 7,312	25,061	403,143 396,464 375,035	1,174,647
3	Lagos Colony	1,469	1,469	225,099	225,099

Source: NAI CSO26/2/15216, Vol. 9-10. Scheme for Preventive Medicine and hygiene in Nigeria: Travelling Medical Officer: 15

The medical officers had to be deployed in the manner indicated in the table partly because only a few qualified persons were available. The cost of keeping medical officers in the interior was also high because of the capital outlay and the difficulty of providing residential houses with adequate water supply and sanitary facilities. Lagos had the highest concentration of European officials and residents as well as better housing opportunities, hence three MOH were assigned to it in spite of

⁷⁴ NAI CSO26/2/15216, Vol. 9-10. Scheme for Preventive Medicine and hygiene in Nigeria: Travelling Medical Officer: 14-16



the relatively small population. Only qualified and duly registered practitioners who also possessed diploma certificate in sanitary science, public health or state medicine were considered for a full-time engagement as MOH. There was a dearth of such officers. As such, a rule made under the public health ordinance in 1930 provided that

Every senior health officer shall be a medical officer of health, and whilst on duty in any place, whether township or not, shall have the power to direct sanitary work of such place and give instruction to all sanitary inspectors, whether in the employment of government or not⁷⁵.

Indeed, the office of the Medical Officer of Health was critical to the dispensation of preventive health care. He had to approve of all plans for public latrine, urines, dustbins and night-soil depots before construction commenced and thereafter gave instruction for their maintenance. It was also his responsibility to monitor developments regarding disposal of refuse and general sanitation⁷⁶. They were formally charged with the responsibility of inspecting all factories, workshops, breweries, assemblies, places of public instruction and recreational centres to ensure proper sanitation, drainage, ventilation and waste disposal.

Therefore, they superintended school sanitation. In the pursuit of health education, they emphasized the role of schools and collaborated with the education department to ensure a sound syllabus for the teaching of hygiene. The lessons covered how to take care of the body, clothing, homes, household utensils and compound. Anti-mosquito work was emphasised. Schools in the major towns benefited the most while those in the rural areas lagged behind. A major obstacle on the path of rural schools was the lack of qualified teachers, for according to W. Seller, the Propaganda Officer, some teachers “possessed only a meagre knowledge of hygiene”⁷⁷. In several rural schools, therefore, hygiene lessons consisted of only “grass cutting and scrubbing of school

⁷⁵ Kingdom. Donald..1958. *The laws of the Federation of Nigeria and Lagos*. Revised Edition. Vol. 5. Lagos: Federal Government Printers: 3094.

⁷⁶ Kingdom. Donald..1958. *The laws of the Federation of Nigeria and Lagos*. Revised Edition. Vol. 9. Lagos: Federal Government Printers: 1988.

⁷⁷ NAI. CSO26/31908/S.1: W. Seller Report on the Tour of Southern Provinces:50.

furniture”⁷⁸. Thus, the course of hygiene had to be strengthened by the introduction of health propaganda units and rural health units. By 1938, the instructional materials and curriculum for the teaching of hygiene had been improved upon. The simple lesson on hygiene put together by Henry Strachan was no longer considered adequate; in the face of the health challenges that accompanied the expansion of European activities in the interior. The new system categorized prevalent preventable diseases into three groups, namely, those spread through moisture, those spread through insect bite and those spread through excreta of men and other animals. The mode of transmission and preventive measures were dealt with accordingly.

Table II: Hygiene lesson created by the Health Propaganda Unit in conjunction with the Education Department.

GROUP 1

A	B	C
Where disease Begins	How it is carried about	How to prevent it
In moisture from the nose, throat and mouth. Examples: tuberculosis, influenza, pneumonia, cerebrospinal meningitis.	Carried in the air by small drops of moisture (spit) from the nose or mouth of people who have the disease. You must keep 2 or 3 yards away from such infected persons.	Difficult to fight. Avoid overcrowding in sleeping rooms, school rooms and public buildings.

GROUP 2

A	B	C
In the bite of insects. E.g. malaria, yellow fever, sleeping sickness, plague	By mosquitoes, flies, fleas, lice, tick, bugs, etc.	Clean, tidy well built houses, clean clothes and bodies, clean safe latrines.

GROUP 3

A	B	C
In the excreta of men and other animals. E.g.	By dirty water used for drinking or bathing, eating	Leave no excreta uncovered so that flies

⁷⁸ NAI. CSO26/31908/S.1: W. Seller Report on the Tour of Southern Provinces:50.

dysentery, typhoid fever, round worms, guinea worms, tape worms, bilhaziasis.	with dirty hands, flies settling on food, leaving excreta uncovered in the bush or by the road side.	can get at it. Have good latrines and use them properly.
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Source: NAI, MH (FED) 1/11 Education Officer Abeokuta Province to Headmasters 26/8/38:40

The table, in Group 1 (B), indicates that social and physical distance which has been adopted and popularised as one of the antidotes to COVID-19 was prescribed against diseases “carried in the air by small drops of moisture (spit) from the nose or mouth” of infected people was taught in elementary schools as far back as 1938. A social distance of “2 or 3 yards” was to be kept away from infected persons⁷⁹. Beyond schools, such lessons were also incorporated into propoganda work and taught in public lectures.

3. INCORPORATION OF PROPAGANDA UNITS AND RURAL HEALTH UNITS

The creation of Propaganda and Rural Health Unit into the health department emanated from the desire to augment and extend the frontiers of health education. In spite of the role of the schools, improvement of village sanitation was slow. There was a dearth of teachers and sanitary officers and the capital outlay required to attain a satisfactory level of employment was huge. They opted for what was considered to be a “less expensive educative measure” to achieve an appreciable elevation of the standard hygiene among the mass of the population⁸⁰. In view of the limited staff, The Health Department could not post resident government sanitary inspector to every town and village. The few appointed, though zealous, could not reach more than a very limited proportion of the residents⁸¹.

Ineluctably, the policy on health education had to be broadened to accommodate propoganda units. The Acting Director of Sanitary

⁷⁹ NAI, MH (FED) 1/11 Education Officer Abeokuta Province to Headmasters 26/8/38:40

⁸⁰ NAI. CSO26/31908/S.1. J. W. Johnson Acting Director of Medical and Sanitary Services to the Chief Secretary to the Government of Lagos, 17/7/35:1.

⁸¹ NAI. CSO26/31908/S.1. J. W. Johnson Acting Director of Medical and Sanitary Services to the Chief Secretary to the Government of Lagos, 17/7/35:1.



Services, Lagos, proposed the establishment of a Health Propaganda Unit with an estimate of £650. It was modelled after London Health and Cleanliness Council and the Baby Duck Councils. The propaganda unit controlled a central fund. It produced and distributed health posters and leaflets. It was charged with the responsibility of compiling, printing and supervising health week programmes. It acquired and equipped a propaganda lorry for public lectures and cinema. An African sanitary inspector was appointed to interpret films in the indigenous language and read out health lectures through the microphone. The stock of films used included "the construction of borehole latrines and construction of modern slaughter houses"⁸². In 1935, twenty-five pounds was spent on cinematograph films, twelve pounds ten shillings on posters and fifty pounds for Dr Gray's projector, and by 1939, the mobile cinema had covered 12,000 miles with over 1000 hours of viewing time.⁸³ Health propaganda was aligned with activities of schools. Going by the policy, school authorities were charged to cooperate and make adequate preparation for the health team by providing their school compounds, ensuring good attendance and helping to make the visit a success.

Between March 11 and April 28th 1937, the Health Propaganda Unit had visited several towns in Western Nigeria, namely Ilaro, Ijebu Ode, Ibadan, Ife (twice), Benin (twice), and Akure. The propaganda tour:

- (1) provided and lectured school teachers on a simple but complete term's work of school sanitation;
- (2) introduced practical demonstration which teachers were expected to use in teaching hygiene in schools;
- (3) obtained information as to the type of health films suitable for the provinces; and
- (4) met the committees of the rural health units and discuss progress and plans for future activities⁸⁴.

⁸² NAI. CSO26/30314. Health Propaganda, 1935-49W. Seller, Sanitary Superintendent to Med. Officer of Health:8.

⁸³ NAI. CSO26/30314. Health Propaganda, 1935-49Memo by J. W. Thomson on the Tour of Southern Provinces: 8-48

⁸⁴ NAI. CSO26/30314. Health Propaganda, 1935-49Report on the Tour of Southern Provinces: 48

The turnout for the propaganda lectures was in all cases impressive, largely because school teachers and pupils were detailed to sensitise members of their families and communities before the arrival of the party. Approximately 75,000 persons attended the public demonstrations in the various places in 1937.⁸⁵ Each visit was followed by a quick inspection of the town to identify and discuss local health problems with medical officers, superintendent of police and local chiefs without the intention of applying sanitation sanctions on the spot. The information obtained formed the bases of the notes and lectures that they gave in subsequent lectures. An African health staff gave or interpreted the lectures to the public in his local dialects. In the two contacts with Benin in 1937, an educated chief “proved himself a most efficient interpreter”. In order to rub in the lectures, the propaganda officer invited an influential member of the community to speak to the people at the end of the lectures in the form of an epilogue. This speech was dramatised in a manner that simulated a screen display. The person speaking, microphone in hand, stood between a projector and a screen on which his silhouette was registered for all to see and “all lip movement could easily be followed”⁸⁶. The comments of the interpreters were scrutinised for errors, which were rectified immediately.

As we have seen, the health authorities did not have to wait for pupils to become adults to fecundate their communities with new ideas. They complemented school work with intensive propaganda through mobile cinema and rural health units in an attempt to achieve mass mobilisation of the people. Besides their primary role of inspection and implementation of sanitary policies, sanitary inspectors were also harbingers and disseminators of new ideas about preventive healthcare. However, the people were more amenable to the influence of the propagandists and the cinema operators because they conducted their business in a friendlier atmosphere, devoid of any form of coercion, unlike the coercive approach of sanitary inspectors. The spectacle of the cinema generated a lot of excitement. The people watched and listened to

⁸⁵ Apart from the western Nigerian town mentioned above eastern Nigerian towns like Awka, Enugu, Onitsha, Umuahia, Uyo, Port Harcourt, Aba and Owerri are accounted for in this figure. See NAI. CSO26/31908/S.1. J. Report on the Tour of Southern Provinces: 48

⁸⁶ NAI. CSO26/30314. Health Propaganda, 1935-49: 49



preventive healthcare ideas attentively and clamoured for more. The subtle and friendly but effective approach in health propaganda contrasted the fear inspired by the presence of sanitary inspectors. News of an impending visit, let alone, physical presence of a sanitary inspector were dreaded. Normal activities were paralysed as the people scampered to tidy up their environment, largely because the fear of punishment rather than an appreciation of sanitary rules were the more important motivation. The units gave incentives in the form of prizes during school competition and baby shows. The idea was to create a new orientation in the practice of preventive healthcare by the people. The use of incentives and competition began to decline during the war years, over-taken by Britain's war needs. Inter-school sporting competition has endured in Western Nigeria but not so for sanitation competition with a reward system for schools, individuals or families, as practised by the Propaganda Unit, in collaboration with the Educational Department in the 1930s.

However, propaganda had some drawbacks. It paid little attention to cognitive development. It aligned more to an attempt to manipulate a people who were thought to be of inferior intelligence. Propaganda was, therefore, manipulative and gave little room for debate and contribution from the recipients. It smacked of a master-servant relationship between the whites and the indigenes and a colonial mentality in which the former were thought to be superior.

Despite their limitations, health education and propaganda raised the awareness of the people about the relationship between the environment and vectors. For the first time, enlightened individuals and those exposed to the principles expressed in preventive healthcare schemes came to know that mosquitoes and flies were not mere irritant but lethal agents that transmitted malaria and yellow fever (in the case of mosquitoes) and dysentery and diarrhoea (in the case of flies). Such knowledge was a major step towards an appreciation of the battle against those vectors. Thus, health education enriched the people with a new consciousness and a scientific alternative to preventive healthcare. Although the pace of appreciation of the policies varied between persons and communities, they gradually percolated into every Western Nigerian

community where there were schools, educated persons, missionaries, dispensaries, hospitals and sanitary inspectors.

In order to address the overwhelming attention given to the provincial headquarters, major towns and the relative neglect of the villages, the health department came up with a policy that instituted a complementary arrangement. The policy entailed the establishment of Rural Health Units. The primary purpose was to stretch the frontiers of health education and preventive healthcare services to the hinterland.

4. THE RURAL HEALTH UNITS (RHU)

The first set of rural health units were formed in November 1937 at Ife, Ilaro, Ondo and Benin and quickly gained recognition as examples of how “a handful of educated Africans can influence a town in health matters”⁸⁷. Each was a representative committee of voluntary workers, who worked side by side with the health propaganda unit to sensitise and create a health sense in the people as well as stimulate the interest of the Native Administration in sanitary improvement. The four towns were selected to commence the project by the Director of Health Service after consulting with the Chief Commissioner and several residents. The Medical Officer of Health and the Propaganda Officer discussed the scheme with the Residents or the District Officers and, thereafter, explained the details to the King (*Oba*) and chiefs. Drawing from their role in running the Native Authority units, the health authorities considered the cooperation of the chiefs a sine qua non for the success of the project. Each Rural Health Unit, as stipulated in the policy, operated as a committee. The committee consisted of the Resident or the District Officer as Chairman, the Medical Officer or Medical Officer of Health as technical and medical adviser, a representative of the Native Administration, An African medical and health staff (if available) school teachers and one or two influential persons in the town. The cooperation of the superintendent of education and agriculture was also sought⁸⁸.

Going by its rules, a rural health unit was a voluntary association and was only “established in a community that wished to have it. Each

⁸⁷ NAI. CSO26/30314. Health Propaganda, 1935-49: : 49

⁸⁸ NAI. CSO26/30314. Health Propaganda, 1935-49. Memo W. B. Johns Director of Medical Service, Lagos to Chief Secretary to the Government 5/1135:39.

member endeavoured, (as he was made to promise), to make his own house an example for others to follow. They gave instruction and helped to organise “clean up days”, dry-pot days and school health display. However, they refrained from sensationalism and, therefore, only engaged in spectacular shows such as health weeks, mobile cinema only when they had gained the confidence of the people. The rural units at Ife, Ilaro, Benin and Ondo kept in touch with each other for the exchange of ideas to cultivate a “friendly competitive spirit between them”⁸⁹.

School health display was another point of cooperation between the health authorities and the schools. The programme could run between one and four days. For example, one was held at Ife from the 22nd to the 24th of April 1937. Its programme of action presented below gives insight into the workings of a typical school health display.

Table III: School Health Display in Ife, 22-24 April 1937

Date	Time	Programme
April 22nd	10.00a	Clean house competition/judging
	m	Parade of school children and judging of banner
	5.00pm	competition at Oduduwa College.
	7.00pm	Cinema display to school children.
April 23rd	10.00a	Judging of school health exhibits.
	m	Physical culture display at Oduduwa College.
	6.00pm	Cinema display to public in the King’s compound.
	7.00pm	
April 24th	4.40pm	Procession of scholars through town to Oduduwa College grounds.
	5.30pm	Physical culture display day the winning team.
	6.00pm	Presentation of certificates.
	6.30pm	Broadcast of essay by the writer of the winning essay competition.
	7.00pm	Cinema display.

Source: NAI. CSO26/30314. Health Propaganda, 1935-49. Rev. M.S. Cole Hon. Sec. Ife Rural Unit

⁸⁹ NAI. CSO26/30314. Health Propaganda, 1935-49. Memo W. B. Johns Director of Medical Service, Lagos to Chief Secretary to the Government 5/1135:41.



Although the Ife rural unit was considered more vibrant, there were also events and displays at Ilaro and Ondo. The story was different in Benin. The town was considered “a little too sophisticated a place for a rural health unit”.⁹⁰ Therefore, the Benin unit did not take off on the same footing as others. The ill-health of Dr McAleer, then Medical Officer, further robbed Benin of a sound beginning. Only school health exhibition and essay competition took place in 1937. However, the Propaganda Officer, W. Sellers noted that the rural health unit had in some ways influence sanitary improvement around administrative quarters in Benin town although compound sanitation did not match the progress made in public places. Arising from the influence of the rural health units and the synergy between them and the Native Administration, the number of labourers in Benin was increased by ten to make a total of forty by 1937. There were twenty-six government labourers at that time. The slaughter slab was also roofed and the sum of £240 was spent on six sanitary units consisting of male and female bucket latrine. The rural health unit also gave lessons to convince the people that latrine should be built at least 100 feet from dwelling places.⁹¹

The rural health units cherished the use of posters as teaching aid. Some of those circulated were provided by the Central Council for Health Education, London. This complemented an earlier one on the prevention of yellow fever, written by Rubert Boyce in 1906. The Native Authority also procured leaflets written in English and ‘vernacular’ from the Health and Cleanliness Council, the Council of Maternity and Child Welfare Centres and the Association for the Prevention of Tuberculosis. Health education generally helped in a better appreciation of hygiene across Western Nigeria. Beneficiaries became better placed to apply its principles to personal, family and community health. Having acquired some knowledge, however, limited, about the human and environmental factors in individual and community health, some individuals made themselves available for assessment in a competitive inspection of

⁹⁰ NAI. CSO26/30314. Health Propaganda, 1935-49: 49

⁹¹ NAI. CSO26/30314. Health Propaganda, 1935-49 Memo W. B. Johns Director of Medical Service, Lagos to Chief Secretary to the Government 5/1135 : 53.



compounds and homes by the propaganda and rural health units for a reward.

The use of local interpreters and school teachers by medical officers reduced the social distance between propaganda officers and the people. The people's involvement helped in the identification and evaluation of local problems and attitudes, which knowledge invariably shaped subsequent plans.

A Rural Health Unit was formed at Illesha in 1938 with Mr Sellers drafted to give a public talk and film demonstration on October 6th with the support of Mr. Creeb, then, Sanitary Superintendent at Oshogbo⁹². But in the opinion of W.B. Johns, Director of Medical Services, Lagos, the rural health committees did little more than holding meetings.⁹³

5. TRAINING OF SANITARY INSTRUCTORS/INSPECTORS

Sanitary inspectors were very important agents in dispensation of preventive healthcare in Western Nigeria. But they were eerily spoken of because of the spectre of fear arising from their role in the apprehension and prosecution of erring individuals. Not even the didactic content of their endeavours was embraced with enthusiasm. They were perceived as odious agents of government who often inflicted pains on people by their persistent demand for sanitary labour. Yet, their training, apart from self-edification in hygiene, made them beacons of light and reservoirs of information on hygiene, which benefitted their communities and places of assignment. The earliest form of training which the sanitary officers got was acquired on the job. It consisted of the instructions, which the medical officers gave in their line of duty. Financial constraints and insufficient manpower encumbered the initial efforts to institute a formal training programme. The financial estimate for personnel and emolument in sanitary services, which was £28,671 in 1917, for instance, could not easily be stretched to accommodate an elaborate training programme for sanitary officers. However, the training of such personnel necessarily had to be instituted on a firm foundation: Health

⁹² Source: NAI, MH (FED) 1/11 Education Officer Abeokuta Province to Headmasters 26/8/38: 30

⁹³ NAI, CSO26/30314. Health Propaganda, 1935-49. Memo W. B. Johns Director of Medical Service, Lagos to Chief Secretary to the Government. 5/1135 :53.

challenges and the frequent outbreak of infectious diseases necessitated the establishment of a well-structured training programme for sanitary inspectors.

A syllabus of training was drawn up for the first time in 1917 when the formal training of sanitary inspectors started⁹⁴. The first set of candidates was drawn from Lagos. The syllabus of training was reviewed in 1930 and brought in line with that of the Royal Sanitary Institute, London. A local board of examiners, an extension of that of the Royal Institute was set up. The first examination was held in Lagos in July 1930. Written, oral and practical questions were administered. Thirty-four candidates sat for the examination of which thirty-two were Nigerians. Two were from the Gold Coast and Sierra Leone. Only six satisfied the examiners as being qualified for deployment as sanitary inspectors⁹⁵.

The demand for sanitary inspectors in Western Nigeria far outweighed the available trained hands. The programme of training, therefore, needed a boost. A training centre was opened in Ibadan in 1933 for a three-year course. The institute admitted twenty-eight pioneer students. By 1934, the number in training had increased to twenty-five. The Ibadan centre served other Yoruba and Western Nigerian provinces extensively. In 1938, the first set from the Benin Native Authority sanitary inspectors graduated from the school and were distributed as follows: three for Benin, three for Esan, and two for Asaba. By 1939, two more arrived in Benin to serve the town and neighbouring districts⁹⁶. Benin Province also had three trained government sanitary inspectors. The inspectors in Asaba increased to four, and served in Asaba town, Ezechima clans, Idumuje, Odiachi, Akwukwu-Atuma, Akumazi, Owa and Agbor clans. The inspectors enlightened the people by their personal examples and campaigns against unwholesome and dirty habits. They explained the benefit of good sanitary practices, disseminated ideas about approved measures, taught the people about anti-mosquito work, sanitary laws and approved sanctions against. They encouraged

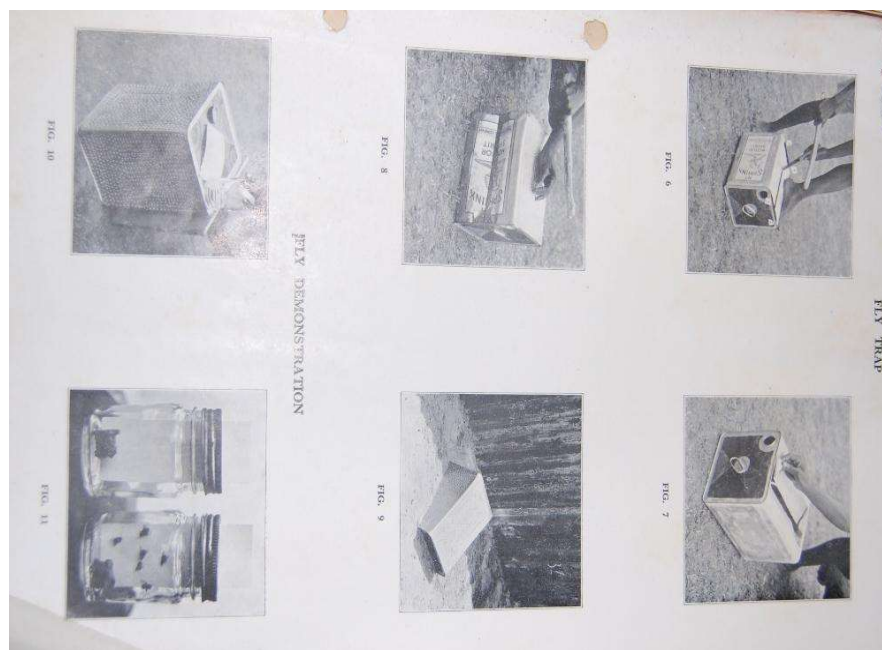
⁹⁴ NAI. W. S. Clark Ag. Directors Sanitary Services, Annual Report. 1925:29.

⁹⁵ NAI. Annual Report. 1935:20.

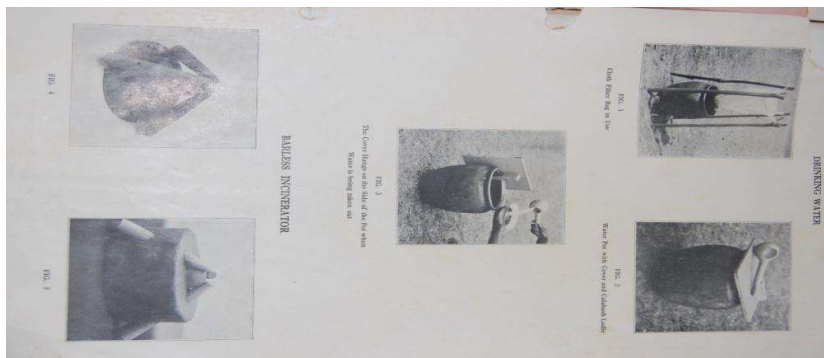
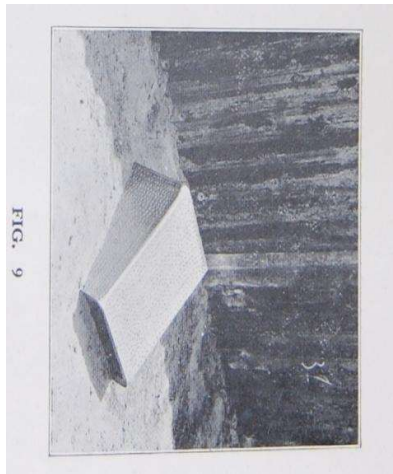
⁹⁶ Shokpeka. S.A., *Local Government and Development, Perspective from Old Benin Province, 1938-1960*. Benin City: University of Benin Press. 2008: 144.

resourcefulness and shared knowledge about improvisation and the making of fly traps. By 1939, such devices had attained some level of sophistication. Major Otaway, then serving in Ghana had designed what became known as the Otaway fly trap. According to him "The newly hatched fly makes directly for the nearest point of light to get out and obtain food. This fact provides me with my line of attack on him"⁹⁷.

Design of a fly trap



⁹⁷ NAI.Oyo Prof 1/895. Quarterly Report on the Sanitation of Ibadan Quarters. 1929. Plan of a Fly Trap Pit. A typical Otaway fly trap was constructed with a wooden gallon case. The top was covered up with a piece of copper gauze. In the centre of the bottom, a circular hole, six inches in diameter was cut, a piece of copper gauze was fashioned into a cone 6 inches high. The bottom diameter of the cone was 7 inches and top 3 inches. The cone was then fitted over the hole with the narrow-end inside the box. The broader end was fitted tightly to the opening cut on the box. Two openings were then cut on each side of box and covered with gauze for observation purpose. The box with the fly trap in it is then fitted over the hole made for it on the top of the pit and packed around with clay to fix it firmly. It was placed ten to sixteen feet from the filling orifice (the latrine hole). The filling orifice was always to be covered and the only source of light should be the fly trap. When properly done, the filling orifice could be opened for at least 5 minutes before any fly would appear.



Source: NAI. Quarterly Report on the Sanitation of Ibadan Quarters. 1929. Plan of a Fly Trap Pit)

Alongside fly trap, Otaway also came up with a new design of incinerators, which was roofed to protect it from rain and guarantee all year round incineration. With this system came the idea of employing barrow boys in addition to incinerator attendant to separate non-combustible materials from the combustible ones. Hot coal and ash were also taken from the incinerator and poured over the droppings to disinfect them and kill the larvae before evacuation by the barrow boys to a dumped in a layer of one to one and half feet in depth.⁹⁸

⁹⁸ NAI. Quarterly Report on the Sanitation of Ibadan Quarters. 1929. Plan of a Fly Trap Pit



A significant contribution of the sanitary inspectors derived from their role in taking hygiene and sanitary instruction beyond the major towns, into the rural districts. To further equip the sanitary officers, malaria experts attached to the Rockefeller Foundation, goaded by the mortality rate, which remained high in the 1930s, trained a sanitary superintendent on how to organize sanitary brigades to further deal with the anopheles mosquito⁹⁹. Cubing the high infant and mortality rate required a specialized antenatal and infant welfare education, which the health department also addressed.

6. MATERNAL AND ANTENATAL LESSONS

Progress and development that were recorded in the teaching of hygiene were not replicated in antenatal clinic and lessons until the 1930s. Traditional, unscientific ideas, which largely remained the basis of maternal and child welfare services, did little to abate maternal and infant mortality. However, the health authorities were slow at instituting programmes to salvage the situation, save for the initial efforts at Massey street clinic in Lagos and some mission hospitals. The dispensaries and African hospitals only served the natives and hardly got the full complement of hospital services. The mission hospitals, as we shall see, did more to incorporate maternity work into their service. Antenatal lesson was critical to the process enlightening expectant mothers about health practices that are congenial to safe delivery. In the same vein, this form of education sensitized the women against unwholesome practices that were inimical to the survival of their babies.

A major problem that had to be tackled in maternal education was the dangerous practices encouraged in traditional procedures. The task of taking delivery across Western Nigerian communities was, largely, an ad hoc responsibility of all the older mothers and grandmothers. This was the case because very often women got to critical points in labour either in their homes or places where 'professional' help was unavailable. It was a common occurrence for babies to be born in farms, in a street or even a market place. In this bizarre circumstance, the older women took charge of the birth process.

⁹⁹ NAI. Annual Report. 1936:18



However, there were traditional midwives who were experts and consultants in pregnancy management and birth-taking. Traditional antenatal lessons were not often helpful. Some, indeed, were harmful. It was common for the pregnant women to be given concoctions that were meant to retard the growth of the foetus and reduce its size, supposedly, to ease delivery¹⁰⁰. A traditional midwife who was patronized by a pregnant woman for antenatal care was expected to help deliver the baby at full-term. She did this skilfully. However, the severed umbilical cord was left gapping or covered with unhygienic materials like, herbs or a piece of cloth, which exposed the child to tetanus, a common infection and cause of death in infants.

Under the colonial dispensation, Western scientific ideas percolated into Western Nigeria, creating awareness about maternal care and child welfare. The status of the foetus as a biological entity was emphasized and correlated with proper medication. These ideas revolutionised the worldview of women especially in the major towns. It also questioned the protective value ascribed to divination, amulets, and the propitiation of spirits, ridiculing them as diabolical and superstitious. However, until 1927, the government had no clear-cut policy on midwifery and maternity lessons for expectant mothers.

The training of nurses in Western Nigeria began in 1896 when two young Nigerian women apprentices were appointed for a three month trial training at the Lagos Government Hospital¹⁰¹. But their experience was not an enviable one as they were almost reduced to domestic servants in the quarters of their trainers and worked under harsh rules such as those that prohibited them from wearing shoes while on duty¹⁰². A report made by Clive J. Sharp, then Resident Medical Officer in Lagos, showed that there were fourteen nurses in training in

¹⁰⁰ Interview with Oti Uabor skilful in traditional birth attendance, 24/12/2013

¹⁰¹ Denzer. L., Female Employment in the Government Service of Nigeria, 1885-1945, Paper presented at the Symposium on Women's Studies in Nigeria at the Institute of African Studies, University of Ibadan. November 4-6. 1987:2.

¹⁰² Denzer. L., Female Employment in the Government Service of Nigeria, 1885-1945, Paper presented at the Symposium on Women's Studies in Nigeria at the Institute of African Studies, University of Ibadan. November 4-6. 1987:3.



Lagos by 1923.¹⁰³ During their first year they were instructed in the practical duties of junior nurses and in elementary anatomy, physiology and hygiene. During the second and third years, more advanced lessons were given in the wards and outpatient department¹⁰⁴. Maternal and infant mortality remained problematic. The health authorities, therefore, had to institute a policy that encourage maternity and child welfare education in modern Nigeria. It created a platform not only for consultation and treatment, but also for the much needed clinical lectures given to pregnant women. It was, therefore, nurtured as an important department in health education and preventive healthcare. The first clinic for maternity work and child welfare was opened at Massey Street Hospital, Lagos in 1926. Within its first year of operation it had produced satisfactory results, to the extent that a columnist in the *Daily Times* of the 21st August, 1928 described its activities as “extremely gratifying”¹⁰⁵. However, there was a certain amount of shyness and apprehension at being examined and treated by the Lady Medical Officer, when the invasion of the female genital was involved¹⁰⁶. By 1928, such inhibitions had started to give way to confidence and maternity work gained in popularity and progressed significantly¹⁰⁷. In addition to the clinic, a school of midwifery was opened in Massey Street Clinic. Girls of “good education and character” were admitted and trained to become qualified midwives not only to serve the clinic but also to “carry on the work outside in the houses of the people”¹⁰⁸. The training policy, therefore, took into account the low level of awareness of a majority of the indigenes, the strong influence of traditional birth procedure and encouraged the trained midwives to offer their services at home when necessary. The Midwife Ordinance was passed in 1930 and became law in 1931. It acknowledged the role of midwives not only as birth attendants but as educators of expectant mothers, within the context of

¹⁰³ Denzer. L., Female Employment in the Government Service of Nigeria, 1885-1945, Paper presented at the Symposium on Women’s Studies in Nigeria at the Institute of African Studies, University of Ibadan. November 4-6. 1987:3.

¹⁰⁴ NAI. CSO26/33329. Vol. 1. Report on the Department of Vocational Education in the Colonies:6).

¹⁰⁵ A columnist, *Daily Times*, 21/8/28:4.

¹⁰⁶ A columnist, *Daily Times*, 21/8/28:4.

¹⁰⁷ A columnist, *Daily Times*, 21/8/28:4.

¹⁰⁸ A columnist, *Daily Times*, 21/8/28:4.

preventive medicine. Massey Street Clinic and the Denton Street Dispensary held infant and expectant mother clinics regularly on Mondays, Wednesdays and Fridays. Total attendance in 1930, for instance was 2,118.¹⁰⁹ In 1936, seven grade one and twelve grade two certificates were awarded. There were 35,956 visits from expectant mothers, 150 infant welfare clinic in Lagos and forty-nine in Ebute Metta¹¹⁰.

Maternity and child welfare work were also approved for the government hospital, Abeokuta and the Mission Hospitals at Ilesha and Ogbomosho. By 1939, all the mission hospitals, in Western Nigeria – namely, Sacred Heart Hospital (Abeokuta), Catholic Mission Hospital (Ijebu Ode), Wesley Guild Hospital (Ilesha), Baptist Hospital (Ogbomosho), Saint Camillius Hospital (Uromi) and Saint Joseph Maternity Hospital (Asaba) and Native Authority Dispensaries at Owo, Ondo, Ilara, Abeokuta also gave maternity services and lessons. They worked with modest facilities, but with passion and enthusiasm. Ilesha and Ogbomosho Maternity centres were recognised by the Midwives Board of Nigeria as centres of training for African girls as midwife grade two¹¹¹. Data provided by R. Briefcliffe, Director of Medical Service in 1937 shows the development of maternity work in the hinterland.

Table IV: Facilities for Maternity Work/Lessons in the Hinterland, 1937

Hospital	No. of Wards	NO. of Beds	No. of Delivery
Abeokuta Catholic Sacred Heart Hospital	6	24	70
Abeokuta Egba NA Welfare Clinic	-	-	Over 100
Abeokuta Government Hospital	1	4	158
Abeokuta African Hospital	1	4	9
Owo (Akure) Native Authority Dispensary	-	-	137
Ondo Native Authority Dispensary	-	-	114
Ilara N/A Dispensary	-	-	126
Ijebo-Ode African Hospital	1	9	293
Lagos European Hospital	1	2	4
Oshogbo	-	-	2

¹⁰⁹ NAI Annual Report. 1930:31.

¹¹⁰ NAI Annual Report. 1936.

¹¹¹ NAI Annual Report. 1937:24.

Government Hospital			
Victoria Hospital	1	1	12

Source: NAI. Briercliffe. R., Director of Med. Services. Annual Report. 1937: 25

The deliveries recorded in the tables give an approximate number of women that may have benefited from antenatal lessons in the hospitals listed. An expectant mother was expected to attend clinics several times. In Lagos, 3,697 clinics were held. A baby week was organized to teach and encourage patronage of maternity centres and forty grade II certificate midwives graduated in 1938, enriching the workforce.

In spite of the gains recorded in terms of increased access to modern maternity services, many women continued to patronize the traditional birth attendants. The enlightenment campaigns in the clinics were more popular in the major towns. The influence of maternity lessons was also curtailed by the fact that most women were illiterates and superstitious, compounded by the near isolation of the village dwellers¹¹². Large dispensaries were visited by the Medical Officer of Health every five weeks¹¹³. Another area where lessons were used to advance the course of preventive healthcare was in the leprosaria and infectious disease hospitals where workers were taught health rules relevant to the prevention of nosocomial infection.

7. HEALTH EDUCATION IN LEPROSARIA AND INFECTIOUS DISEASE HOSPITALS

Taking up a job of any description in an infectious disease hospital or a leprosarium was a risky venture. Conventional training in nursing and sanitary institutions did not adequately address the peculiarities of these specialized health institutions. Clerical officers, labourers, caterers, that had no medical training whatsoever were invariably at greater risk. This challenge was addressed in the policy which required the medical officers in charge and the sanitary superintendents to administer engagement and refresher lessons to

¹¹² A Columnist. *Daily Times*. 28/8/28 :4

¹¹³ NAI. Annual Report Abeokuta ABE Prof. I, ABP 1367:62



prospective and already employed workers. Thomas Lawson emphasized such training in the foundational years of Yaba Leper Asylum, which had commenced operation by 1896¹¹⁴.

In leprosaria, there were two sides to the lessons given – personal hygiene and hospital hygiene. Personal hygiene entailed compliance to general sanitary rules applicable to every individual with emphasis on the regular washing of hands, bathing daily, after work, regular washing and ironing of clothes¹¹⁵. On the other hand lessons on engagement hygiene were tailored towards dealing with inevitable administrative contact with leprosy patients. Workers were counselled to avoid recreational and casual movement within and around the leprosarium. A critical part of the training involved the need to minimise physical contact with the inmates. Written messages between the staff and inmate were submitted or received glove in hand. The conduct and degree of compliance to these instructions were monitored by the Medical Officer in charge and appropriate corrections or sanctions were given. These ideas were reinforced by instructions and lectures given by sanitary superintendents. A delegation of technical experts headed by Dr Ernest Muir of the British Empire Leprosy Relief Association re-echoed these ideas during their visit to Ossiomo Leprosorium in 1935. In infectious disease hospitals in Lagos, Ibadan, Benin and Warri, and indeed all hospitals, workers were taught the general rules of hygiene and hospital guidelines to prevent a nosocomial spread of smallpox, tuberculosis, yellow fever and other infectious diseases¹¹⁶.

Every effort coalesced around government policies and given the government's central role in health education, its engagement in World War 11 was to impact significantly its commitment to the funding of training and propaganda work.

¹¹⁴ NAI. Annual Report 1928:34.

¹¹⁵ Interview with Onobhayedo Patricia, Clerical Officer, Ossiomo Leprosorium. 1955.

¹¹⁶ According to Dr. Felix Ogbeide, former Director of Ossiomo leprosarium, 1991 – 2010, interviewed on 3/3/15, some of these measures, apart from personal hygiene were unnecessarily discriminatory and were stressed beyond reasonable limits. He stated further that those already cured or in advanced stages of treatment could exchange agricultural products with their host community safely. See NAI. Annual Report 1936 – Report on Medical Services: 6



8. IMPACT OF WORLD WAR II ON HEALTH EDUCATION AND PROPAGANDA WORK

The vicissitudes of World War II affected the commitment of the colonial authorities to health propaganda. Having re-ordered its priorities to suit its war needs, it came up with a policy, which held that “money from the Colonial Development and Welfare Fund cannot now be made available except possibly in connection with projects directly concerned with the war efforts”¹¹⁷. As a result of the ensuing reduction in funding and the redeployment of staff, propaganda work suffered a major setback during the period. According to G. W. Walker, Acting Director of Medical Services, Mr Sellers who perhaps was the most active Health Propaganda Officer up to the beginning of the war, was “retained in England”. Besides, the last evidence of the servicing of the mobile cinema vehicle up to the end of the World War II was in September 1938 based on the request made by the Director of Medical Services to the Mechanical Engineer of the Public Works Department at Ijora. The cinema became less available because it was expensive to run. Funds were diverted from such venture to the army. To compensate for this, the health propaganda unit had to emphasise the use of printed materials and posters as well as reliance on schools, teachers (especially travelling teachers), sanitary inspectors, vaccinators and dispensary attendants.

Propaganda posters were distributed to several schools. The Native Administration bought copies from the C.M.S Bookshop, Lagos. *The Longman African Hygiene pictures* were very popular in the early 1940s. So also, were *School and Domestic Sanitation for Rural District* written by the Health Propaganda Unit of the medical service in conjunction with the Education Department¹¹⁸. According to the Director of Medical Services, Lagos, this approach was to ensure continuity and “improvement and economy of efforts” in spite of the limited financial

¹¹⁷ NAI, MED (Fed) ½-435: Memorandum from T.E. Dods, Acting Commissioner of the Colony to Salvation Army Authority, June 21, 1940: 41.

¹¹⁸ NAI, MH(Fed)/1/11. Health propaganda unit: supply of models and general, correspondence. Director of Medical Services, Lagos to the keeper of Medical Service and Sanitary Stores, Lagos.



support from government¹¹⁹. The down-turn in propaganda work was of such concern by 1944 that the Director of Medical Service lamented:

Training of adolescents and adult through propaganda units until recently (was impressive)...Organized health exhibition, health weeks and displayed films on health subjects; Unfortunately, no substitute propaganda officer to replace Mr Warminger invalided from the service or Mr Sellers seconded to the colonial office... so that recently it has been more or less dormant¹²⁰.

The opportunity of acquiring and disseminating knowledge on preventive healthcare also reduced with the near abandonment of the West African Medical Journal as a result of the war and the ensuing "difficulty in securing articles for publication"¹²¹. As a palliative, the Director of Medical Services, Lagos in 1944 recommended the establishment of a colonial magazine to support government efforts in health education and propaganda work. This idea remained undeveloped by the end of our period – 1945. The West African Medical Journal was only resuscitated after the war, in 1952, when resources could be allocated to such a venture with the first volume of the new series featuring two articles on malaria in Nigeria.

It follows, therefore, that the level of sophistication of propaganda work and health education was curtailed by the removal and none replacement of experts like Sellers and Warininger. The input of propaganda officers in public lectures, film demonstration and supervision of rural health units and refresher lessons for teachers in school diminished and became less vibrant and effective. However, health education was not completely jettisoned. Schools and the education department remained partners and facilitators while formal hygiene lessons in schools continued. However, some new elements were incorporated and "dealt with by both medical and educational departments", especially lessons about venereal diseases, which became

¹¹⁹ NAI. Medical policy of the colonial empire, NAI:CSO26/40976, the DMS, Lagos to Hon. Chief Sec. of Govt. Lagos, 23/6/44:28.

¹²⁰ NAI. Medical policy of the colonial empire, NAI:CSO26/40976, the DMS, Lagos to Hon. Chief Sec. of Govt. Lagos, 23/6/44:30.

¹²¹ NAI. Medical policy of the colonial empire, NAI:CSO26/40976, the DMS, Lagos to Hon. Chief Sec. of Govt. Lagos, 23/6/44: 34.



more rampant as a result of the exuberance of soldiers, which Lord Cranborres reported in 1943¹²². The enlightenment campaign and free treatment offered soldiers in general were extended to venereal diseases. The problem of venereal disease became so acute among the soldiers, ex-servicemen and even the middle aged men that new rules were promulgated as control measures in 1944. Anyone infected was required by law to consult a medical officer who was expected to report same to the Medical Officer of Health of the area within ten days. This was followed by a more detailed monthly report of all cases. The rules made it mandatory for such a patient to submit himself for further examination and treatment, until he was certified cured by the Medical Officer of Health. A certificate of clearance was to be issued to a cured patient or his parent if he was a minor¹²³. Where the health authorities believed that venereal diseases were prevalent “amongst the residents in any premises or locality in region” he issued an order requiring the examination by a Medical Officer of Health of any person or persons of any specified class or description residing therein¹²⁴. Causes and effects of venereal diseases were incorporated into health education schemes to push the frontiers of health education. Such measures helped to keep the disease within manageable limits by minimising coital spread between couples and sexual partners.

Arising from these developments, when the Western regional government was constituted in 1951 under the McPherson constitution, a modest foundation had been laid for health education as an essential element of preventive medicine in Western Nigeria. Little wonder, therefore, that the preventive healthcare policy articulated by the Western regional government in 1952 incorporated health education and advocated a “vigorous campaign of preventive medicine”¹²⁵. However, the attention paid to health education and health propaganda has atrophied over the years, with occasional reawakening of interest during pandemics such as the Ebola and COVID-19 pandemics. This indicates a

¹²² NAI: Memo Oliver Stanley to Gov. Bernard Bourdillon, CSO 26-40976. 17/3/43:9.

¹²³ Kingdom. Donald.,1958. *The laws of the Federation of Nigeria and Lagos*. Revised Edition. Vol. 2. Lagos: Federal Government Printers: 2563.

¹²⁴ Kingdom. Donald.,1958. *The laws of the Federation of Nigeria and Lagos*. Revised Edition. Vol. 2. Lagos: Federal Government Printers: 2563

¹²⁵ NAI. PR/F3. Public Health Policy for the Western Region, Nigeria 1952. Lagos. Government Printers:1.



need to revisit the lessons and reservoir of ideas of the colonial past, in order to extract useful ideas to rekindle the flame of public health education.

9. CONCLUSION

The colonial authorities laid a modest foundation for health education in Western Nigeria, having perceived it as veritable means of disseminating information about how to prevent and manage several tropical diseases that confronted the people and threatened the interest of the colonial state. It involved measures like the teaching of hygiene in schools, routine public lectures, propaganda work, antenatal lessons, use of cinema, use of posters and pamphleteering. However, the persistence of practices such as open defecation, the poor attention paid to hygiene, low turn-out for vaccination and the spate of environmental pollution in all its ramifications, portray a failure of the people to internalise the lessons inherent in the efforts of the colonial past. Public lectures on hygiene have been abandoned and no policy has been formulated to accommodate health education in the burgeoning Nigerian movie industry in line with the use of the cinema by the colonial authorities. Besides, sanitary superintendents and inspectors no longer visit schools and hospitals in Western Nigeria on a routine basis.

It follows, therefore, that there is much to learn from the foundation laid for health education within our period of study. Encapsulated in the experience of the period is a pool of ideas and strategies, a reservoir of knowledge that can be sieved, harnessed and improved upon to deal with intractable endemic diseases like malaria, tuberculosis, leprosy, schistosomiasis, worm infestation, dysentery and diarrhoea, which in contemporary times have been listed by the World Health Organisation among Neglected Tropical Diseases (NTDs).

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