Segregation in the Provision of Public Sanitation to Indigenes and Europeans in British Southern Cameroons: A Historical Investigation

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Abstract

This paper analyses the segregative attitude of the British in the provision of public sanitation as a preventive healthcare initiative in colonial Southern Cameroons. The paper demonstrates that, contrary to the popularly held view that sanitation was only intended to serve the local population, it was actually anchored on the wider colonial agenda meant to preserve the health of Europeans and also to ensure a healthy labour force which was constantly being threatened by the high incidence of non-infectious diseases. Sanitary Inspectors engaged by British Colonial Administration and Native Authorities (NAs) educated the population on sanitary practices, implemented rules and regulations pertaining to cleanliness, visited markets, homes with the purpose of inspecting food and toilets and guarding against other diseases whose prevalence had a negative impact on the attainment of colonial interests. This effort resulted in the prevention of some diseases, thus, enhancing the health of the population and facilitated the economic exploitation of the territory. Primary and secondary sources from the National Archives Buea and libraries around Cameroon respectively were consulted. In its analysis, the paper combines both the qualitative and quantitative approaches within a thematic mold guided by strict historical chronology. Deriving from these sources, the paper contends that the dynamics and travails of public sanitation hinged on encounters, negotiations and hybridization of the ideas and interests of Europeans and Southern Cameroonians. This study reveals a picture of an ill-intentioned, poorly conceived and managed public sanitation structure that was installed and operated in the territory.

Keywords: *Segregation, Indigenous, European, Public Sanitation, Southern Cameroons*

Introduction

Health disasters were not only detrimental to the economic and social ambitions of Africans, but also to the exploitative agenda of their European colonizers. While the prevalence of diseases stalled the advancement of African societies,

they also served as speed brakes on the exploitative agendas of colonial agents:governments, traders, planters and missionaries. Surmounting the prevalence of these diseases such as malaria, chickenpox, smallpox, and sleeping sickness was championed by many actors with various intensions. In Southern Cameroons, just like elsewhere in colonial Africa, disease prevention and control were vital components of the healthcare system. The British mandate-trusteeship colonial administration in Southern Cameroons designed a healthcare system that gave plenty of attention to preventive services. This was in a context of high disease prevalence that was stalling the attainment of colonial goals, including the mandate and trusteeship health obligations. British colonization and exploitation of the territory rested on the ability of the government and private actors to develop preventive health services. This revolved around the prevention of diseases and resultant epidemics that threatened the health of Europeans and indigenes on whom colonial exploitation rested. These preventive services took the form of quarantine laws, vaccination campaigns, housing regulations, sanitary services, dietary services, potable water provision, and involved an array of actors: government, Native Administration, Christian missions and plantation firms. In this paper, the provision of sanitary services is examined with a view to determining their imprint on the health of Southern Cameroonians. It is argued that sanitary initiatives which were primarily intended to limit illness among Europeans (colonial officials, missionaries, traders and planters) and Southern Cameroonians (labourers, porters and, maybe, the rest of the population) were mostly effective in areas where colonial exploitation was concentrated. There were several areas across the territory which were neglected health wise simply because they were remote from towns and colonial exploitation centres.[1]

Considering that high disease prevalence in Southern Cameroons just like elsewhere in Africa was attributed by colonial medical staff to the absence of preventive healthcare, more attention was thus given to the fashioning of a preventive healthcare policy. As a matter of fact, evidences of the lack of preventive healthcare measures such as poor hygiene, inadequate sanitation, and poor dietary habits were at the origins of continual outbreaks of dysentery, malaria, small pox, chicken pox, yaws, and diarrhea among other epidemics. Death toll among the indigenous population was high and the European population was also threatened by these epidemics. These recurrent epidemics that had come to be interpreted as obstacles to the colonial agenda necessitated the development of sanitary services, whose blueprint came in policy form. Intended to prevent the outbreak and spread of epidemics that would threaten individual health, the preventive healthcare policy with roots traced to the 1917 Public Health Ordinance (whose initial application was limited to

[1] NAB, File No. Sc/a(1917)6, Public Health Ordinance, 26 July 1917.

Nigeria) came in the form of broad public health measures such as quarantine laws, vaccination procedures, sanitary and scavenging regulations.[2] The 1917 Public Health Ordinance recognized the recurrence of infectious diseases and called on all administrative officials in the divisions to be on the alert for the first indications of any increased mortality attributed to a particular disease. Consequently, colonial administrators were expected to collaborate with the medical staff by providing information on mortality cases in their areas of jurisdiction. But the greatest public health duties, according to the ordinance, fell on the shoulders of medical officers as can be seen following:

> *Every senior health officer shall be a medical officer of health and while on duty in any place whether a township or not shall have the power to direct the sanitary work of such place and to give instructions to all sanitary inspectors, whether in the employment of the government or not. It shall be the duty of any medical officer of health to inspect the areas to which he is appointed and to abate nuisances and otherwise to enforce the powers vested in him relating to public health.*[3]

The ordinance identified what it referred to as nuisances to public health (a combination of numerous unhygienic practices with a potential to threaten public health) and commissioned health officers to fight against such irritants through a plethora of measures.

Background of the Study

In 1922 when Southern Cameroons became administratively attached to Nigeria, the application of the 1917 ordinance was extended to the territory, though such extension initially remained on paper. But the Divisional and Medical Officers that were stationed in the four divisions had the duty to enforce the provisions of the ordinance. In 1927, other provisions were injected into the ordinance for its practical application in Southern Cameroons.[4] The new provisions came with the policy for the establishment of Sanitary Units across the territory. These units which were manned by Sanitary Inspectors came into existence in 1929. The public health ordinance was applied only in divisional headquarters which had been classified in 1925 as second-class towns. Central in the preventive healthcare policy was the training and deployment of Sanitary Inspectors in Southern Cameroons, and this task was accomplished on a collaborative basis between government and private actors.

Within each division, the Native Administration was associated with public health work as all NAs were required to draft village sanitary rules. But there was also the 1927 Labour Ordinance which had some provisions relating to

[2] Ibid
[3] Ibid
[4] NAB, File No. Sc/1925/1, Medical Department Correspondence, 1925.

preventive healthcare in the camp settlements. These preventive health rules were laid bare in these words:

> *The Labour Camps were to be far off from swamps, bush, jungles or any thick undergrowth. Streets were to be at least 30 feet wide. All building sites were to be sufficiently drained from any animal, plant or any offensive matter. Potable water was to be available at most within half a mile from the camp without which adequate wells must be constructed with stones and parapet walls graded away from the well's mouth (...). No domestic animals were to be allowed within the camp but slaughtering was to be permitted at a distance of at least 150 yards from the nearest house. No refuse, blood, dung or any other offal was to remain after slaughtering. But to be burnt or buried immediately (...). The rule also provides that the authorized officer might serve on any person offending against the foregoing regulations by issuing a written notice calling upon him to remedy the offence. He was to demolish as the need might be and as he deemed necessary5.*

Throughout the 1930s, the 1917 ordinance and 1927 Labour Law were therefore the blueprints for preventive healthcare in Southern Cameroons. These provisions were enforced by preventive medical staff, especially, sanitary inspectors, who were engaged by government, plantation firms, missions and NAs. The laws were applicable in domains such as public sanitation, vaccination against diseases, environmental sanitation, dietary services and infant welfare. Much later in 1943, due to the persistence of epidemics, a new Public Health Ordinance was drafted and promulgated. It was not completely a new public health policy as it merely expanded what had been in application. In fact, the ordinance whose application went right up to 1961 contained guidelines with regards to the safe disposal of sewage, refuge and related nuisances in public places. The ordinance also extended public health to the clearing of grass around compounds, draining of breeding grounds for mosquitoes, provision and protection of potable water and the need for every household to own a latrine.[6]

The legal dispositions in the territory (be them NA Courts or government courts) were empowered to ensure the strict implementation of these public health rules. As such, violations of these ordinances by both the population and medical personnel could result in litigations and punishment in the courts. These ordinances and legal dispositions put in place for their enforcement are pointers to the fact that disease control was very important to the colonial political economy. The incidence of epidemics due to the non-respect of public health practices posed as an impediment to Britain's exploitative agenda. It was with this in mind that all actors in the health sector (government, NAs,

[5] NAB, File No. Sc/a(1927) 1, Miscellaneous medical correspondence, Victoria Division, 1927.
[6] **T.N. Tebo,** "Public Sanitation in British Southern Cameroons 1922-1961: A Historical Evaluation", DIPES II Dissertation in History, HTTC Bambili, 2014.

missions and plantation firms) were commissioned to promote public sanitation within the framework of the ordinances, with the undeclared objective of ensuring that the population remained healthy for the general benefit of the colonial economy.

Public Sanitation in Southern Cameroons

In colonial Africa, the impact of sanitation on disease prevalence was acknowledged by medical staff and efforts were made to associate the promotion of hygiene and sanitation with the preventive healthcare system. The Medical Department in Southern Cameroons was conscious of the relevance of sanitation. Consequently, at the inception of the mandate period, the low or near absence of sanitation was considered as the major cause of the high incidence of sanitation-related diseases like cholera and dysentery. As a matter of fact, the 1920s and 1930s were decades marked by recurrent outbreaks of epidemics in Southern Cameroons, with diseases such as yaws, dysentery, diarrhea, chicken pox, and small pox taking the lead. Annual and quarterly medical reports carried information on the occurrence of these diseases and the various ways in which they affected the health of the population.[7] The medical personnel, especially the Medical Officers stationed in the divisions were unanimous in recognizing safe sanitation as an essential foundation for better health, welfare and economic productivity. This was the context in which public sanitation became a corner stone of Southern Cameroons' healthcare system. The medical team committed their initiatives towards reducing the impact of sanitation-related diseases that afflicted Southern Cameroonians and Europeans settled in the territory. So, public sanitation was extended to both Europeans and indigenes.

Public Sanitation among Europeans

Understood at that time as the handling of human excreta, domestic waste and associated hygiene, the Government, Mission, Plantation and Native Administration medical staff committed themselves to the promotion of public sanitation. By that time, Southern Cameroonians practiced indiscriminate or open defecation which had a direct impact on health. This and many insanitary practices heightened the incidence of diseases, with some attaining epidemiological levels. The death toll was huge and the colonial government began by promoting public sanitation among the European population via the controversial policy of sanitary segregation. It was a policy aimed at protecting the health of Europeans by ensuring that they were segregated from the indigenes whom the medical staff considered as unclean and exposed to infectious diseases. This sanitation approach was imported from Nigeria, especially Lagos with its high number of European settlers, where it was running its course at the hands of British colonial medics.[8]

[7]NAB, File No. Sc/a(1923)13, General Station Matters, Sanitary Conditions Victoria, 1923.

[8] Read Laszlo Mathe-Shires, "Who Lives Where? British Anti-Malaria Policy in Southern-Nigeria (1899-1912)",

Southern Cameroons' colonial towns such as Victoria, Buea, Mamfe, Kumba and Tiko attracted many Europeans who functioned as administrative officials, traders, planters and missionaries. Caring for this European population on racial grounds was imperative. Sanitary preventive services were initially directed towards the European population in these towns. Considering that contacts between Europeans and indigenes could result in disease transmission, sanitary segregation was thus adopted as a policy for protecting the health of Europeans. In Victoria, Tiko and Buea, Europeans lived in separate quarters where strict respect for sanitary procedures was encouraged. The Medical Officer for Victoria Division was given firm instructions by the Resident to station sanitary workers in European residential areas and to routinely supervise sanitation work.[9] In these areas, there was the provision of facilities such as toilets and potable water to reduce the incidence of disease. Sewage disposal facilities were also made available and the constant clearing of grass in these areas was encouraged.

In Mamfe, the Divisional Officer in 1925 called on the Medical Officer to engage in sanitary improvements in the government station that was inhabited by Europeans. Keeping the station clean by cutting the grass in and around it was stressed by the Divisional Officer:

> *The most necessary urgent sanitary necessity is a gang of labourers able to clear off long grass and rubbish in the two inhabited ridges of the station and keep in repair the drains necessitated by the hollows north and south of the more southerly ridge. In my opinion twelve labourers are a very bare minimum and presuppose more assistance than an average of 6-8 H L prisoners and 8 station labourers can afford. Twenty men will nearer the mark.*[10]

There were similar requests from government officials in all the divisions of the territory who wanted to protect the health of Europeans. The medical staff that coordinated sanitary work in these places engaged in regular exercises which were supervised by the Medical Officer. In Victoria, the Medical Officer employed the services of a European Sanitary Inspector who was empowered by the 1917 Public Health Ordinance to promote hygiene and sanitation among Europeans. The sanitary segregation policy which undoubtedly favoured Europeans was pursued throughout the period of British administration. The benefits of the policy for Europeans were evident and grew over the years as pointed out in most annual medical reports which had rubrics on the health of Europeans in the territory. A 1935 medical report for Kumba Division observed on the health of Europeans in these words:

Comm. de Artis Med., 2001, pp. 174-177 and Adetiba Adedamola Seun, "Malaria and Sanitation in Colonial Lagos: A Historical Appraisal", *History Research*, Vol. 3, No. 6, 2015, pp. 65-71

[9] NAB, File No. Sc/a(1923)13, General Station Matters, Sanitary Conditions Victoria, 1923.

10NAB, File No. Sc/a(1925)2, Medical Department Correspondence, 1925, p. 15.

> *This has been very fair. One case had Amoebic Dysentery and there were few cases of mild malaria while one unofficial was invalid with heart disease and one Missionary was killed by lightning in the bush. Everyone is affected sooner or later with filariasis and I consider all offices at least should be screened against Chrysope for with them in the offices, it is quite impossible to concentrate on one's work.*[11]

The foregoing excerpt is indicative that sanitation was the hall mark of European health during the first two decades of British administration. The rest of the period of British Administration witnessed significant improvement in sanitary work among Europeans, with the Principal Medical Officer Dr. C. Kelsall noting in his 1960 medical report that "The health of the expatriate population has been fairly good. The common diseases among them are malaria, dysentery, filariasis and fungus infection of the feet. No deaths were recorded during the year."[12] With this in mind, it is difficult to escape the conclusion that sanitary segregation as a public sanitation approach was specifically designed for the European population. It had a special sanitary perspective that was extended only to the European population. Little wonder the incidence of infectious diseases among them as well as ensuing deaths dropped progressively during British administration. The rest of the sanitation work was extended to the indigenous populations and was largely abandoned in the hands of Native Administration, missions and plantation firms' sanitary workers.[13]

Public Sanitation among the Indigenous Population

While sanitary work in Europeans residential areas was carried out by white sanitary inspectors with a few indigenous workers under their service, public sanitation work among the indigenous population was largely in the hands of indigenous workers who were employed by the NAs, missions and plantation firms. The 1917 Public Health Ordinance which provided the blueprint for public sanitation required that its takeoff should be preceded by the training of Sanitary Inspectors to be deployed across the territory. But the initial years of British administration were marked by the flouting of this rule, perhaps, due to lack of commitment on the part of the administration. Throughout the 1920s and most of the 1930s, sanitary work among Southern Cameroonians lacked organization and was bedeviled by the absence of qualified staff. According to Teboh, "Until 1935 sanitary activities in British Southern Cameroons were carried out by untrained or unqualified sanitary superintendents, mostly of Nigerian origin."[14]

This is evidence that while trained white Sanitary Inspectors were brought in from Nigeria to promote public sanitation in European residential

[11] NAB, File No. Sc/a1926/2, Medical Report, Kumba Division, 1935
[12] NAB, File No. B.99/Vol. III, Annual Medical and Sanitary Report, 1960, p. 3.
[13] Teboh, "Public Sanitation", p. 56.
[14] Ibid

areas, such work among the wider population was initially left in the hands of unqualified staff. Across the territory, NAs were simply told to engage in sanitary work by creating Mobile Sanitary Police whose entire membership was unqualified. No doubt the outbreak of epidemics that could be prevented through public sanitation remained consistent, with ravaging effects on the population. This initial inability of NAs to promote public sanitation caused government to also give attention to hygiene and sanitation in government hospitals in Bamenda, Kumba, Victoria and Mamfe. It began with the creation of a Sanitary Unit in the territory's Medical Department in Victoria whose role was to oversee sanitary work in the various divisions. There was no clear distinction between purely medical services and sanitary work. This meant that more attention was given to curative work with sanitary work stalled by inefficiency and lack of personnel.

It is important to point out that in government hospitals, the sanitary staff simply comprised labourers who were clearing and sweeping in the hospitals and in other government services. Commenting on these services, Forkusam noted with dismay, and in his own words declared: "They were general labourers who did cleaning in these areas. There was then no one among them who could be termed a sanitary inspector. In the stations they cleaned compounds, emptied night- soil buckets, and filled burrowed pits that would otherwise hold water and breed mosquitoes".[15] From the above quotation, the early years of sanitary work targeting Africans in Southern Cameroons were trial ones, unfolding in a context of government commitment to safeguard the health of the expatriate white population on racial grounds, no doubt. In 1925, the small pox epidemic in the Mamfe Division and dysentery epidemic in parts of the Bamenda Division in the late 1920s were simply results of this neglect of sanitary work among the indigenous population.

At the turn of the twenties, efforts to commence sanitary work among the indigenous population were started when government began working in collaboration with NAs in the training of Sanitary Inspectors. As these negotiations were still in gestation, some sanitary workers were employed in key towns across the territory after receiving brief training at government hospitals. These locally trained Sanitary Inspectors thus became the initiators of public sanitation in places such as Wum, Fundong, Nkambe, Kumbo, Bamenda, Mamfe, Kumba and in many other towns. Their job assignment was to educate the population on how unclean practices were at the origin of the numerous infectious diseases they suffered from. It was thus the task of the inspectors to see into it that rules and regulations pertaining to cleanliness were respected in view of rolling back the incidence and frequency of some diseases. Dressed in completely white uniforms, the sanitary inspectors visited markets and homes inspecting food items and general cleanliness. It was their role to call the attention of the population to the dirty practices in public

[15] **Forkusam, L.A.,** ''The Evolution of health services in the Southern Cameroons under British Administration: 1916-1945.''DES Dissertation in History, University of Yaounde, 1978.

places such as markets that were harmful to the population.The benefits of the activities of sanitary inspectors drew the attention of almost all NAs to it. From the mid-1930s onwards, government made it clear that it was the duty of each NA to finance and carryout sanitary work in its area of jurisdiction. The recruitment, training, buying of sanitary equipment and payment of sanitary staff had to be borne by the NA with funds generated from taxes and court fines. This marked the beginning of the training and recruitment of qualified sanitary staff. With limited funds and knowhow, the NAs were forced into a partnership with the government, with the latter facilitating the admission of Southern Cameroonians into Nigerian Sanitary schools.[16] In 1938, the Resident of the Cameroons dispatched a circular note educating and encouraging all Native Authorities to select and send candidates for training in Nigerian schools.[17] Responding to this request, NAs in all the four divisions of the territory expressed two difficulties: inability to have qualified candidates and lack of finances with which to sponsor the training. Chief Manga Williams of the Victoria Native Authority went as far as noting that his NA could sponsor a candidate who might refuse to work for the NA upon his/her graduation. On the basis of these reactions, the Resident in consultation with the Medical Department concluded that the scheme for the training of NA Sanitary Inspectors could not be immediately applied.[18]

Training and Deployment of indigenous Sanitary Inspectors

With the proper organization of the NAs and their coming to terms with the indispensability of public sanitation, the training eventually took off. For candidates to qualify for training, they had to be holders of the First School Leaving Certificate and a pass in high school. This marked the beginning of the training of Sanitary Inspectors in Nigerian medical institutions such as the Kano School of Hygiene, the Aba School of Hygiene, the Nsukka School of Hygiene, the Health Auxiliary Training School at Ibadan, the Medical Auxiliary Training School at Kaduna and the Lagos Town Council Training Centre.[19] When Southern Cameroons transitioned into the Trusteeship Period, Native Administrations in the Kumba, Victoria, Mamfe and Bamenda divisions had sanitary staff with a capacity to perform functions that were beyond mere clearing and cleaning. The entire public sanitation program came to lay in their hands under the supervision of medical officers. Such trained sanitary staff was also placed at the disposal of other actors in the health sector such as the missions and plantation firms.

During the Trusteeship era, this sanitary staff engaged in a plethora of sanitary work ranging from disease inspection, alerting medical officers on the

[16] Presbyterian Church in Cameroon Central Archive Buea (PCCCAB), File No. Rule B1 vol. 2, Southern
Cameroons Native Authority Staff Rules, 1943.
[17] NAB, File No. Sc/1938/1, Training of NA Sanitary Inspectors by Native Administrations, 1938.
18 Ibid
[19] Teboh, "Public Sanitation", p. 57.

incidence of diseases, inspected food stuffs, water supplies and public places such as schools, hospitals, dispensaries and markets. The 1947 annual report to the Trusteeship Council of the United Nations carried a rubric on health which, inter alia, described the situation of sanitary work in Southern Cameroons in these words:

> *The staff consists of a Sanitary Superintendent and six Sanitary Inspectors. There are also twenty Native Administration Sanitary Inspectors under the control of the Medical Officer of Health who work more specifically under the medical and district officers in the out-stations. A small staff of trained hygiene personnel is maintained by the Cameroons Development Corporation for work in their own labourers' camps. These camps are also supervised by the Medical Officer of Health and his staff. The health staff carries out general sanitary supervision, epidemic control and malaria control throughout the province.*[20]

It emerges from the above citation that public sanitation was receiving more attention from government, NAs and plantation firms, especially the CDC. Of the 21,190 pounds allocated for the health sector by government in 1947, over 30 percent went into preventive healthcare, particularly public sanitation. The NAs injected 3,728 pounds into rural health work which mostly took the form of public sanitation.[21] Under the supervision of the Sanitary Superintendent in collaboration with government Sanitary Inspectors that were stationed in the divisional headquarters, sanitary work was undertaken by NAs, CDC sanitary and hygiene personnel. They were able to construct twenty-one rural water points and a piped water supply for Bamenda. Besides, the collaborative work involving government, NA and CDC sanitary personnel permitted the re-planning and reconstruction of markets, construction of incinerators and public latrines. In Victoria specifically, public latrines were transformed into water- borne type. In most of the NAs and major towns, unannounced visits were made to schools and markets for inspection works.These often went together with talks by the sanitary staff on best hygiene and sanitation practices in such public places.[22]

An innovation of the Trusteeship era was the inclusion of hygiene as a subject in the curriculum of all government, mission and Native Authority schools which were required to adopt measures of sanitation approved by the sanitary officials and these schools were inspected routinely.[23] In spite this progress in the promotion of public hygiene and sanitation through staff training, finance allocation, inspection work and innovations in water supply and defecation infrastructure such as latrines, progress in public sanitation was generally

[20] NAB, File No. AB78, Report on the Cameroons Under United Kingdom Trusteeship to the Trusteeship Council,
1947, p. 83.
[21] Ibid
[22] Ibid p 85
[23] Ibid p 84

slow. The colonial government attributed this state of affairs to "ignorance, apathy and illiteracy."[24] But this could not have been the only impediments on the path of public sanitation. Suffice it to mention that irrespective of the heightening of training, public sanitation staff remained grossly insufficient. The area that was placed under one sanitary worker was vast and impracticable; a situation that perturbed his numerous tasks. The finances, despite the meager progress already pointed out, were inadequate, with sanitary workers placed on very discouraging salaries. These factors all acted in combination to impede work on public sanitation, with disease and epidemic persistence being major fallouts. While the incidence of disease among Europeans was rolling back, it hardly reduced among the indigenous population. This was enough indication that beefing up public sanitary services intended for the indigenous population was a dire necessity.

By 1950 the situation had not witnessed any admirable change given that sanitary inspectors continued to work under difficult conditions as they endeavored by propaganda to improve existing conditions and enforce the adoption of sanitary measures. In fact, advancement was still slow as admitted by the colonial administration in its 1950 report.[25] The training of sanitary workers stalled as the territory could boost of only thirty-two government and Native Administration Sanitary Inspectors in 1952.26 The persistence of epidemics and diseases incidence in the territory in the last years of British administration did not come as a surprise. In 1954, disease prevalence underpinned by dire sanitation practices was reported. Cases of hyperendemic malaria, intestinal helminthiasis, dysenteries, yaws, ulcers, scabies, venereal diseases, schistosomiasis, hookworm, and leprosy were rampant. There was also sporadic sleeping sickness and at intervals there were epidemics of small pox, cerebro-spinal meningitis, pneumonia and measles.[27]

The efforts of the few sanitary staff to promote public sanitation was therefore not yielding the expected dividends. They did their usual duties as houses, markets, schools and health facilities were inspected. Regarding the inspection of houses in 1953 and 1954, the sanitary workers conducted house-to-house inspection in places that were within their reach and some of the persons whose homes had evidences of non-respect of sanitation rules were referred to the NA courts (see table 1) the persistence of epidemics and diseases.

[24] Ibid

[25] NAB, File No. AB81, Report on the Cameroons under United Kingdom Trusteeship to the Trusteeship Council,
1950, p. 126.

[26] NAB, File No. AB83, Report on the Cameroons under United Kingdom Trusteeship to the Trusteeship Council,
1952, p. 131.

[27] NAB, File No. AB85, Report on the Cameroons under United Kingdom Trusteeship to the Trusteeship Council,
1954, p. 96

Table 1: House to House Inspection by Sanitary Workers, 1953-1954

Houses Inspected	43962	33383
Clean Houses	29845	23069
Dirty Houses	14117	10314
Houses with mosquito larvae	508	317
General mosquito index	1.15%	.94%
Notice issued	864	484
Prosecution	253	145
Convictions	188	11.3
Fines	£319.15	£2.18.9

Source: NAB, 1955 Annual Medical Report, Southern Cameroons, p. 17.

The number of patients who visited the four government hospitals suffering from diseases that the sanitary workers failed to prevent through their sanitation initiatives was significant in 1956. Table 2 below portrays patients' attendance in government hospitals in 1956.

Table 2: Patients' Attendance and Deaths in Government Hospitals, 1956

	In-Patients	**deaths**	**Out-Patience**
Respiratory Tuberculosis	153	3	77
Dysentery	565	14	962
Malaria	839	14	4305
Helminth Infection	215	-	6509
Pernicious and other Annemias	90	6	465
Diseases of the eye and ear	130	-	2027
Bronchitis	208	2	2952
Pneumonia	920	54	477
Diseases of the Skin and cellular tissues	839	2	7564

Source: NAB, File No. AB63, 1956 Annual Report, Cameroons under the United Kingdom, p. 94.

From the above table, it is indicated that public sanitation positively affected patients' attendance and deaths in the territory, the out-patients dominates in-patients and deaths.

As the termination of the United Nations Trusteeship drew nearer, the British had started to reflect on the end of their administration in Southern Cameroons. There was also the intensification of nationalist activities across the territory, which, no doubt, shifted attention away from the health sector, especially as regards the domain of public sanitation. As such the closer supervision of the work of NA and CDC Sanitary Inspectors by government sanitary officials at

the medical headquarters in Victoria as well as those stationed in divisional headquarters was no longer effective. Public sanitation work now came to rest almost entirely in the hands of indigenous sanitary workers. Filled with determination in a context of imminent independence, the indigenous sanitary workers continued the inspection of nuisances in homes, markets, hospitals and schools. The 1960 medical report described the activities of the sanitary staff in these words:

> *Compounds and lands were inspected regularly by mosquito scouts in townships. Receptacles likely to collect water for mosquito breeding were buried. Stagnant water and small pools were sprayed with oil. Compounds and houses were also sprayed with insecticides using the four oak sprayers, knapsacks, and swing fog machines. Drains were dog in townships to prevent stagnation of water. No spectacular improvements were recorded during the year on mosquito control because of inadequate funds. Only 1,020 pounds was voted for the whole territory for the period under review.*[28]

Going by the above excerpt from the medical report, it quickly emerges that public sanitation was now significantly shouldered by indigenous sanitary staff, with the expatriate sanitary staff simply reporting their activities. This was not good for the efficacy of preventive healthcare as the activities of these persons coursed in a context of limited finances and equipment. Moreover, their work was being limited to the growing towns with rural areas left with few or no sanitary inspectors. Consequently house-to-house inspection statistics did not witness any admirable improvement. In 1959 and 1960, for instance, statistics on the inspection of nuisances in homes by sanitary inspectors were not really better than those for 1953 and 1954. The table that follows lays bare these statistics with accompanying analysis on the last years of public sanitation under British administration.

Table 3: Inspection of Nuisances in Southern Cameroons by Sanitary Inspectors, 1959-1960

	1959	**1960**
Houses Inspected	43910	38271
Clean Houses	30334	26344
Dirty Houses	13576	11927
Houses with mosquito larvae	699	701
General mosquito index	1.59%	1.83%
Notice issued	1294	1625
Prosecution	930	380
Convictions	627	325
Fines	£1,125	£803

[28] NAB, File No. B99/Vol. 111, Annual Medical and Sanitary Report for Southern Cameroons, 1960, p. 10.

Source: NAB, File No. B99/vol.III, Annual Medical and Sanitary Reports, Southern Cameroons, 1960.

Actors of the colonial public sanitation interventions

With a rationale underpinned by a complex web of intertwining agendas, public sanitation in Southern Cameroons required rigorous effort that involved an aura of actors. Colonial government, mission agencies, Native Administration, nurses, teachers, dispensers and the male and female peasants. But the key actors in the provision of public sanitation were colonial government mission agencies and Native Administration. The engagement of the trio in the development of sanitary services was a negotiated process, initially motivated by the realization that the alarming insanitary practices which had been neglected by the Germans was an impediment to their agendas. The British portrayed themselves as committed to enhancing the wellbeing of the Southern Cameroons population in accordance with Article 2 of the mandate agreement.[29] The missions whose presence in Southern Cameroons came only after World War One (with the exception of the Basel Mission) following Britain's recourse to the policy of terminating the work of German missions saw intervention in public sanitation as a catalyst for conversion to Christianity. The Native administration headed by traditional rulers involved public sanitation within the blueprint of the indirect rule policy.[30] As local government representatives, traditional rulers raised funds with which they promoted socio-economic development, including public sanitation. These chiefs participated with government and Christian missions in the development of child welfare programs.

The three actions were changed with the implementation of public sanitation programs which involved the training and recruitment of staff, construction of the necessary infrastructure, and ensuring that the staff and services were at the service of the population. In medical schools in Britain, Nigeria and Southern Cameroons, prospective sanitary staff took courses on how to roll back maternal ignorance of infant care, and hygiene, which according to colonial medical doctors were responsible for the prevalence of diseases. The white medical officers were supplemented by local recruits. This together with Britain's interest resulted in efforts to end what was wrongly described as inadequacies in indigenous public sanitation. Resulting from these public sanitation inadequacies which accrued from surveys conducted in the 1920s was that government commitment turned the situation around in partnership with missions, traditional rulers, and local population. Thus, rolling back public sanitation rearing ignorance become a hallmark of sanitary services that were developed. No doubt, the centrality of the public sanitation interventions rested

[29] The mandate agreement in it Article 2 made Britain responsible for the promotion to the utmost of the material and morale wellbeing and the social progress of southern Cameroonians, read N.Rubin ,Cameroon :An African Federation(London, Pall Mall Press,1971)PP.199-203.

[30] Indirect Rule was a British colonial Administrative policy through which Africans where constituted in to local administrations and administered through their chiefs.

on baseless and culturally ignorant assumptions which portrayed Southern Cameroonian as failing in the duty of hygiene.[31]

Building on such flawed assumptions, the British reached the conclusion that the development of public sanitation would take the form of mobile sanitary inspectors with the task of providing knowledge and advice to the indigenous population. This required collaboration between the medical department, mission agencies, Native Administration, and the education department as sanitary inspectors had to visit schools and teach pupils about hygiene and child care. This was the context in which public sanitation interventions were launched in the 1930_s. It was to involve a plurality of actors and varying agendas which eventually accorded credence to the view that the development services in Southern Cameroons were a negotiated process between the colonial administration, missionaries, medical officers, nurses, traditional rulers, and African dispensers.

Generally, public sanitation in Southern Cameroons was the collaborative initiative of government, NAs, missions and plantation firms. It involved the training of sanitary inspectors by these bodies and their deployment in plantation camps, schools, hospitals, markets, major towns and in villages where they carried out numerous sanitary tasks. Intended to improve sanitation with a view to preventing the contraction of diseases such as malaria, small pox, chicken pox, diarrhea, yaws, dysentery, tuberculosis, whooping cough among others, public sanitation was able to reduce the incidence of some diseases. However, the work of sanitary staff was challenging as they were hugely insufficient, covered vast areas, and lacked adequate finances. Their attainments depended on the incredible low wages and harsh working conditions imposed on them by their colonial bosses.

Furthermore, the limited sanitary services within colonial Southern Cameroons were distributed in a manner that reflected the pattern of domination and exploitation. Improved sanitary services such as latrines, potable water and general cleanliness as well as the deployment of sanitary workers were greatest in the plantation camps, European settler towns such as Buea, Victoria, and Tiko and in government hospitals that were reserved for whites. Primarily, public sanitation services were geared towards the wellbeing of settlers and the indigenes that were used as tools of their own exploitation. Little wonder, the incidence of preventable diseases was highest among the indigenes than whites. Hence, the white racial superiority which was a hallmark of British colonialism also found expression in colonial Public sanitation.

Conclusion

This study has focused on the engagement of the British in the provision of public sanitation as a preventive health care initiative in Southern Cameroons.

[31] It was noted in the introduction to this paper that southern Cameroonians where not ignorant of proper ideas and practices of public sanitation. Before the introduction of western sanitation practices, Southern Cameroons was a world where public sanitation was practice for the rolling back of diseases

The underlying reason for the establishment of this preventive health care service was, first, to ensure the good health of European personnel stationed in the territory and secondly, to ensure that Southern Cameroons workers, especially, those working in the coastal plantations were in good health so as to ensure an all-year-round supply of the vital labour force, a condition *sine qua non*, for the fulfillment of the colonial agenda of exploiting the much- needed resources of the territory. Again, the paper has noted the duality in the attempt by the British to provide preventive health schemes like public sanitation in the territory. Europeans living quarters had been carefully carved out far away from the masses of Southern Cameroonians. Accordingly, these quarters had special and well-designed sanitation schemes manned by European medical personnel whilst locals were taken care of by African personnel trained in some of the intermediate health institutions established by the colonial system. In all therefore, there were two standards of preventive health care deliveries operating within the region ostensibly for the welfare of the territory but more for the overall wellbeing of the European colonizers.

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