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Sleeping Sickness Epidemic in British Southern Cameroons 1922-1961: The History of a Colonial Medical Response

Michael Kpughe Lang*

Abstract

This article examines the engagement of the British colonial administrative and medical officials in the campaign against the sleeping sickness epidemic in Southern Cameroons. The engagement was informed by the disease's negative bearing on the colonial agenda and involved the implementation of control policies. The campaign had three fronts: treatment in humans, treatment in animals, and efforts to get rid of the tsetse fly. The control measures which overlooked indigenous coping strategies were misdirected, brutal, and flawed. Enforcing these measures involved complex interactions between colonizers, colonial subjects, and local intermediaries. This occasioned socio-economic disruptions and indigenous resistance as livelihoods were depleted. While control measures boosted exploitative colonial investments, they triggered low economic productivity and underdevelopment among the local populations as they were deprived of access to food, travel, trade, and job opportunities outside their communities. This was destructive to communal life, economically painful, and aggregately harmful to indigenous pride, wellbeing, and survival.

Keywords: Southern Cameroons, sleeping sickness, colonialism, exploitative, resistance, survival.

Résumé

Cet article examine l'engagement des responsables administratifs et médicaux coloniaux britanniques dans la campagne contre l'épidémie de maladie du sommeil dans le Cameroun occidental. L'engagement était justifié par l'impact négatif de la maladie sur l'agenda colonial et impliquait la mise en œuvre de politiques de contrôle. La lutte s'effectuait sur trois fronts: le traitement chez l'homme, le traitement chez les animaux et l'éradication de la mouche tsé-tsé. Les mesures de contrôle faisaient fi des stratégies d'adaptation des populations autochtones et étaient mal ciblées, brutales et imparfaites. Leur application impliquait des interactions complexes entre colonisateurs, sujets coloniaux et intermédiaires

* Department of History, Higher Teacher Training College, University of Bamenda. E-mail: mickpughe@yahoo.com

locaux. Cela a occasionné des perturbations socio-économiques et une résistance des indigènes en raison de l'épuisement des moyens de subsistance. Les mesures de contrôle ont certes stimulé les investissements d'exploitation coloniaux, mais elles ont entraîné une faible productivité économique et le sous-développement des populations locales, qui ne bénéficiaient d'aucun accès à la nourriture, aux voyages, au commerce et aux emplois en dehors de leurs communautés. Cela était destructeur pour la vie en communauté, économiquement douloureux et nuisait globalement à la fierté, au bien-être et à la survie des autochtones.

Mots-clés : Cameroun occidental, maladie du sommeil, colonialisme, exploitant, résistance, survie.

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 the various colonial agents: governments, traders, planters, and missionaries. Fighting these diseases thus became the concern of Africans and Europeans. The fight against endemic diseases such as smallpox, sleeping sickness, chickenpox, malaria, dysentery, etc. was characterized by the plurality of actors (Africans and Europeans), with various agendas at play. Africans who partnered with Western medics in the struggles saw their involvement as significant for improving health with a view to rolling back the negative bearing of such health disasters on development. Their European bosses had a different agenda as they viewed a healthy African population as an indispensable element in the attainment of the exploitative goals of colonialism (Baronov 2008:2). On the balance sheet of colonial campaigns against epidemiological diseases, there are both credits and debits. While the campaigns improved the health of Africans, they were associated with European exploitation, with a negative bearing on local livelihoods.

There was very little interest in healthcare in rural areas except in crisis situations when disease could have a negative bearing on the colonial agenda, particularly through diminishing the productivity of its workforce. This triggered wider curative and preventive campaigns against epidemiological diseases, chiefly as responses to health crises that were threatening the colonial agenda, rather than the implementation of comprehensive long-term medical initiatives. This reinforces the argument that colonial medicine was inbuilt into broader colonial ambitions. European colonial policies in Africa were couched in economic terms, given that the economies of Britain, France and Germany were dependent largely on the resources and labour of the rest of the world (Rodney 1972:161). Little wonder that imperialist powers in

Southern Cameroons (initially Germany from 1884 to 1916 and later Britain, officially from 1922 to 1961) implemented colonial policies geared towards gaining control over raw materials, labour, markets and means of communications. This comes close to suggesting that sleeping sickness had a direct effect upon the formulation of colonial administrative policy. The disease was endemic in areas already identified as potential sources of labour. The British colonial administration believed that a demographic crisis brought about by sleeping sickness could seriously affect the supply of labour and disrupt the colonial economy. This is corroborated by Lyon's description of control measures against sleeping sickness as a facet of colonialism intended to ease exploitation.

While discrediting the celebratory defence of colonial medicine by mostly Western scholars, critics have argued that it had selfish motives and overlooked the basic healthcare needs of colonized populations (McKeown 1977; Baronov 2008; Roberts 2015; Osaak 2002:285). This debate is also reflected in the works that have dealt with the history of sleeping sickness in the African context. Some have been written by colonial medics who see the colonial struggle against sleeping sickness as an efficient humanitarian venture that was beneficial to African communities (Gelfand 1953; Ransford 1983). Machila lauds the contributions of colonialism to the fight against sleeping sickness in Zambia by noting that the British South African Company 'carried out appropriate measures that were intended to contain and prevent the spread of tsetse flies and trypanosomiasis' (Machila 2013:iv). Since the 1990s a contrary view has been espoused in works written mostly by African historians. Lyons associates the measures against the disease with Western cultural arrogance, ignorance, and dubious colonial agenda, arguing that control measures were ill-intentioned, foreign to the local context, and defective (Lyons 1992). While agreeing with Lyons' thesis, Bivens goes further to blame European colonial intrusion and the ensuing disruptions for the exacerbation of sleeping sickness epidemics. He contends that the delicate ecological equilibrium between indigenous groups, animals, and disease hosts such as the tsetse fly was disrupted by colonial economic investments in ways that heightened the frequency and gravity of the disease (Bivens 2015). In Bivens' thinking, the outbreak of the disease in cyclical epidemiological proportions and the stringent control measures were underpinned by the colonial agenda.

Graboyes also holds colonialism responsible for making sleeping sickness attain epidemiological proportions. He pins down the interplay between colonially-induced population displacements, ecological balance disruptions, overlooking of indigenous disease control mechanisms, and the outbreak of terrible epidemics in the example of sleeping sickness (Graboyes 2010:7).

From an ecological perspective, Jordan and Ford, in separate studies, show that the colonial environmental transformations and trypanosomiasis control measures were couched in colonial terms, with implications for the trends and African responses to the disease (Ford 1971; Jordan 1986). They contend that the campaign against sleeping sickness can only be won if the tsetse fly is eradicated.

These studies reveal a correlation between colonialism, sleeping sickness exacerbation, and control measures. Thus, caught up in a health disaster which they had helped to exacerbate and which was threatening their investments in Africa, colonial agents, in combined efforts, enforced flawed and often brutal measures to contain sleeping sickness. This paper takes a cue from these studies to contribute to the debate by situating sleeping sickness in Southern Cameroons in the broader discourse of disease control in colonial Africa. It documents the complex interactions between colonizers, colonial subjects, and local intermediaries that characterized control measures against sleeping sickness in Southern Cameroons.

Southern Cameroons offers an interesting case study for understanding how colonialism exacerbated the epidemiology of sleeping sickness, necessitating recourse to experimental and often problematic Western disease preventive and curative measures. As early as the German era, population and ecological mutations resulted in outbreaks of sleeping sickness epidemics in the area that came to be known as British Southern Cameroons after the First World War (Rudin 1968; Correa 2012). Rudin discusses the failed attempts by German doctors to understand and contain the disease. The successive British mandate and trusteeship administrations inherited this health disaster. Repeated outbreaks of the disease, particularly in the Mundane and Tombel areas in Kumba Division, Fontem and Mundani areas in Mamfe Division, and Nso and Menchum Valley in the Bamenda Division, had an adverse imprint on demographic patterns, and thus threatened colonial investments. It was in this context that Southern Cameroons experienced efforts by colonial administrative and medical workers to contain and eliminate sleeping sickness. The efforts were both curative and preventive, with resultant disruptions on local populations and their communities. This important dimension of the socio-medical history of Southern Cameroons has been overlooked or missed so far in existing literature. Little historical enquiry has been made into trypanosomiasis in the area as the subject has been scratched from the surface and swept into general works on colonial medicine (Forkusam 1978; Mokake 2011; Tebo 2014). This academic gap needs to be filled given that the modern Cameroon state is still grappling with sleeping sickness, though its gravity has shrunk over the years (Ghogomu 1989:231).

The current study pins down the labelling of colonial medicine as a colonial apparatus by examining the policies initiated and implemented by the British colonial administration to curb the sleeping sickness epidemic in Southern Cameroons. The medical personnel that were charged with the implementation of the control measures, I argue, played the dual role of professionals and colonizers. This determined the direction and quality of the medical response to sleeping sickness. As such, the study pulls into its analysis the role of disease control measures as a hallmark of veiled British colonialism in Southern Cameroons. It opens with an examination of the underlying motives of the campaign to contain and eliminate sleeping sickness in the territory.

Rationale for the campaign against sleeping sickness

The high incidence of sleeping sickness in Southern Cameroons, especially in the forest region, was a cause for concern among colonial agents. The cyclical epidemics caused the disease to be ranked by colonialists, missions, and local population through their chiefs as a major public health problem. The death toll from the disease was alarming, with some villages abandoned by inhabitants in order to flee from the disease, with a glaring imprint upon demographic patterns. The entire territory from the Mungo River to the Cross River, from the Menchum River to the Katsina Ala stream in the Bamenda Grassfields was infected. The disease was prevalent in all the river valleys, with the area lying between the river Meme and the Cross River heavily infected. Although there was a precedence of dealing with the disease in communities in the territory, successive German and British colonialism triggered an ecological crisis in various parts of Southern Cameroons. The opening of plantations, expansion of the road network through various ecosystems, and increased circulation of people exacerbated sleeping sickness. This provoked unprecedented cyclical trypanosomiasis epidemics, with rapid dispersions across the territory. There was a complete disruption of the ecological balance between indigenous groups, animals, and the disease hosts.

The cost of the exacerbation of sleeping sickness was huge, and it was borne by both the indigenous population and European colonizers. The deaths triggered by the disease were shocking to the local population. The infection rate was high with dramatic resultant suffering. This scourge affected every aspect of life including food production, social relations, and individual existence. It ravaged the animal population and had a huge bearing on the wealth of the local human population. In places such as Nso, Mbaw, Bafut, Wum, Menchum Valley, Mamfe, Kumba, and all the divisions of the territory where the disease was reported, the population was worried. Colonially-induced disruptions had caused the disease to outpace traditional control measures. Previously, the disease was contained by locating villages and

farms in ways that reduced contact between man and the tsetse fly. Such farms and villages were now infested by the fly, placing these innocent people at the mercy of a disease they had not caused. Controlling this disease concerned the local population, especially their traditional rulers whose role it was to ensure the wellbeing of their citizens. Little wonder they collaborated with the colonial administration in implementing control measures against the disease. Their goal was to roll back the incidence of the disease, reduce the number of deaths, and overcome the economic and social dilemmas accruing from the epidemics.

Colonial agents were even more disturbed considering the bearing of the disease on their investments. There was workforce loss and the disruption of commercial networks. The scourge had a negative bearing on trade, the plantation economy, and other investments. In the Victoria Division where most plantations were established in places such as Bonaku, Mulanga, Mbongo village, Missaka, Tiko, Bwinga, Bimbila, and Missellele, surveys in 1929, 1930, and 1933 respectively by teams led by doctors P.H. Rawson, E. Williams, and C.E.G. Nunns, often with assistance from local chiefs, revealed an increasing prevalence of sleeping sickness.¹ It was discovered that the Sonne, Essoasso and the Ndongo rivers that flowed through Likomba and Tiko to the sea were infested with tsetse flies. The 1933 team examined 7,952 persons, most of whom were plantation workers. Of this number, 1,065 were carriers of the disease, revealing a very disturbing 13.6 per cent incidence distributed as in Table 1.

The initial focus of surveys in the plantation zones is a pointer to the fact that the disease was threatening huge colonial investments. This situation corroborates Lyon's description of control measures against sleeping sickness as a facet of colonialism intended to ease exploitation. The rest of the territory was only surveyed in 1938, with its report indicating the gravity of the disease in labour-supplying areas such as Mamfe, Fontem, and Mundani in Mamfe Division; Mundane and Tombel areas in Kumba Division; and Mbaw and Menchum Valley areas in the Bamenda Division.² It was particularly noted in the 1938 survey report that 'In infected areas, there is a decline in the birth rate, as the disease destroys the virility of men, and the fertility of women'.³ This comes close to suggesting that sleeping sickness had a direct effect upon the formulation of colonial administrative policy. The disease was thus endemic in areas already identified as potential sources of labour for the flourishing plantation economy seated principally in Victoria Division. The British colonial administration believed that a demographic crisis brought about by sleeping sickness could seriously affect the supply of labour and disrupt the colonial economy.

Table 1: Sleeping sickness diagnosis in Victoria, 1933

Area	Number examined	Positive cases	Incidence in %
Guatemala Plantation	1,040	68	6.54
African Fruit Company	2,188	212	9.69
Holtforth Plantation	426	86	20.65
Misellele Plantation	1,056	218	20.64
Ombe Plantation	111	23	20.72
Bwinga Plantation	298	46	15.44
Tiko village	1,344	164	12.20
Likomba village	414	60	14.49
Ebonji village	82	17	20.73
Misellele village	212	59	27.8
Mukota village	40	9	22.5
Bonaku village	84	5	5.95
Bonangolu village	21	6	28.57
Mudika & Bopulu village	78	15	19.23
Bonamenja & Kongwe village	124	12	9.68
Mulanga	13	2	15.39
Missaka na Bonasong, Njopongo & Egango	371	55	14.82
Ebonji village	26	5	19.23
Missaka na Bonabanda village	24	1	4.17
Total	7,952	1,065	13.39

Source: Sc (1933) 1, Sleeping Sickness and Tsetse Fly Investigation, 1933, p. 87.

It is, however, unfortunate that full details of the diagnoses for the rest of the territory are not available, chiefly because they were not registered. Available survey reports carry sporadic statistics like the 17 cases that were diagnosed at Bansa Hospital in January 1939 and the 38 positive cases diagnosed at Mundame in April 1940. This lack of statistics was acknowledged in 1950 by the Director of the West African Institute for Trypanosomiasis Research (WAITR), headquartered in Kaduna, Nigeria. 'Present up-to-date information', observed WAITR's Director in a letter to the Senior Medical Officer in Southern Cameroons, 'consists almost of the reports of the M.O. i/e of the Cameroons Medical Field Units, and the areas surveyed have been too scattered to give an overall picture of this disease.'⁴ But the incidence of the disease, as this letter reveals, was widespread in Mamfe and Victoria divisions.⁵ However, awareness of the prevalence of the disease in plantation zones and in labour-supplying areas triggered the urgency to contain and control sleeping sickness in Southern Cameroons. The control measures hinged on an aura of intertwining factors: the effect of the disease upon demographic patterns, the disease's bearing on colonial investments, and its potential to impact upon the formulation of colonial administrative policy.

The effective beginning of the British colonial mandate administration in Southern Cameroons in 1922 was preceded by international imperial efforts at understanding and taming sleeping sickness. In 1907, London was host to an international conference on the disease. Subsequent conferences were held in Paris in 1928 and in Brazzaville in 1948 (Scoones 2014:5). These gatherings assembled colonial authorities and medics with the intent of brainstorming on control strategies. The gatherings necessitated the creation of the International Scientific Committee for Trypanosomiasis Research in 1949. Such robust efforts evidence a synergized imperial effort aimed at rescuing an exploitative colonial enterprise caught up in the trap of sleeping sickness. The gravity of the disease and the necessity to bring it under control were further revealed to Britain by researchers at the Liverpool School of Tropical Medicine and the West African Institute for Trypanosomiasis Research (WAITR) in Kaduna, Nigeria (Courtin et al. 2008:339). This context explains why the British colonial administration was committed to the enforcement of control measures across Southern Cameroons.

Thus, the gravity of sleeping sickness challenged the wellbeing of indigenous populations and obstructed colonial investments and missionary work in Southern Cameroons. The disease came to be associated with sickness of animals and people, low economic productivity, and failure of colonial agendas. The urgency of containing the disease was thus endorsed by both the local population and colonial agents, though with conflicting agendas at play: survival versus exploitation. There was consensual concern

that the intended and unintended benefits of colonialism for both Africans and their Europeans colonizers were being undermined by the disease. As such, response to the scourge came through the combined work of the colonial medical service, administrators, veterinary service, and native administration.

Dynamics of sleeping sickness control measures

Seen as a threat to the socio-economic wellbeing of the local population, the British colonial project of 1922-1961, and a challenge to medical researchers, it was necessary that sleeping sickness be controlled. The colonial administration in Nigeria to which Southern Cameroons was attached instructed the medical researchers at the West African Institute for Trypanosomiasis Research (WAITR) in Kaduna, Northern Nigeria, to thoroughly investigate and understand the prevalence of sleeping sickness in Southern Cameroons with a view to elaborating a control policy. Survey teams worked in the territory from 1929 to 1938 in an effort to understanding the incidence of the disease. The research missions comprised doctors, epidemiologists, bacteriologists, and colonial administrators. The surveys, as noted earlier, confirmed earlier reports by colonial administrators and medical doctors that there was a high incidence of the disease in the territory. Outbreaks of the disease were reported in Tiko, Victoria, Missellele, Mundame, Tombel, Fontem, Mundani, Nso, and in some Menchum Valley polities. The teams recommended an organized attack on sleeping sickness and advocated for an examination of the entire population and curing all the cases found. It identified civic consciousness as a means of boosting the full and willing cooperation of the local population. A reduction of the tsetse fly population was also suggested by the team.

Building on these recommendations and experiences in other British possessions, a sleeping sickness control policy was designed for implementation in Southern Cameroons. It was a series of measures, which included campaigns for diagnosis, case isolation and treatment, closing of infected areas, monitored movements, and efforts at eliminating the tsetse fly. This control policy came in the form of a Sleeping Sickness Ordinance instituted in 1937.⁶ To ensure its proper implementation, a Sleeping Sickness Service headed by a specialist redeployed from the WAITR was created at the Medical Field Unit in Kumba. Implementing the control policy was the task of this service, though in constant collaboration with medical researchers in Nigeria. From 1938 to 1940, intervention preparations were made by the Director of the Sleeping Sickness Service, V. Hughes, administrators, medical doctors, and traditional rulers. In all, a team was prepared, centres made available in chosen areas, and civic education carried out by administrators.

Traditional rulers were informed and the population mobilized to show up at the centres for diagnosis. Centres were chosen for their accessibility to large sections of the targeted population.

In June 1940, the team began work in Kumba Division, particularly at Mundame and Tombel under the leadership of Doctor T.H. Dalrymple.⁷ These localities were thought to be the epicentres of the disease following reports by administrators and medical doctors. After a careful screening, infected cases were identified, isolated, and treated by the use of chemotherapeutic drugs such as Suramin and Tryparamide. Similar interventions were carried out in the Mamfe and Bamenda Divisions. In the Nso area, twelve infected cases were found and treated out of 398 cases examined. The survey report described the examination of patients in these words:

The people to be examined are brought in as early as possible in the morning, and pass one by one before a member of the team, who feels their necks for swollen glands. If swollen glands are found the person is taken to the rumfa, a gland is punctured, and the fluid microscopically examined for trypanosomes, whose presence indicates a positive case.⁸

The treatment of positive cases at the time consisted of a course of nine injections, given at intervals of five days. Absolute regularity in attending for treatment was indispensable, and all nine injections had to be taken. This explains why case detention was enforced in some places to ensure that each infected person completed the treatment so as to curb relapses, which were common. Resistance by patients was regular, with some escaping from the detention centres. In a letter to the District Officer of Bamenda Division, the Assistant District Officer for Kumba Division reported how Ogen Sonfa escaped to Tingong from a detention centre in Mukonje.⁹ Following the issuance of a warrant of arrest, Sonfa was arrested and forcibly placed in treatment. Earlier in April 1940, the Medical Officer of the Bamenda Division, T.H. Dalrymple, diagnosed five patients in the Mbaw area, three of whom had escaped from the Bansa Hospital without completing their treatment.¹⁰

Besides diagnosis and treatment, the survey team implemented measures aimed at eliminating tsetse flies in particular areas. The goal was to push back the fly belts to avoid reinvasions in areas where people had been diagnosed and treated. This required the full collaboration of the administration, traditional rulers, and local population. With mobilized local labour, bushes along water courses were cleared, to the satisfaction of the colonial administration. In Kumba, Mundame, Fontem, and Mundani, community compliance to this measure was obtained through the mobilization of the population by village headmen. There was large-scale bush clearing with machetes provided by the colonial government. Such community

mobilization and compliance failed in some places, especially in the Bamenda Division where people in communities refused to heed to orders from their chiefs to clear dense bush on the borders of streams. Writing on this issue to the Senior District Officer for Bamenda Division, the Medical Officer in charge of the division described traditional rulers as 'bad chiefs'. The Chief of Ntem in the Mbaw area, however, received praise from the Medical Doctor for clearing all the bush from the streams himself with his family and *Chindas* (palace servants) when his people refused to do the work.¹¹ This was how the tsetse fly habitat was destroyed in Ntem with a resultant drop in the number of infected cases. In the other communities, control measures were almost limited to treatment, as the tsetse fly depopulation efforts met with resistance.

Later in 1947, after World War Two, German-owned plantations were turned into a government corporation named as the Cameroon Development Corporation (Aka 2002:76). This heightened the urgency to continue enforcing control measures against sleeping sickness and other diseases, given their negative bearing on agricultural investments. The Colonial Development and Welfare Fund disbursed significant funds for the anti-sleeping sickness campaign. In 1949, the Sleeping Sickness Ordinance of 1937 was amended, with the inclusion of forceful eviction of infected persons from their homes, monitored movements, control of tsetse fly disease of cattle, and obligatory felling of timber in inhabited areas. The implementation of the revised ordinance began in 1950, with the Sleeping Sickness Service working closely with researchers occasionally dispatched by the WAITR. A new drug, Antrycide, was introduced to cure and prevent trypanosomiasis in cattle. The drug was issued to the Veterinary Department for general use. In areas where the disease was endemic, Antrycide was given to domestic animals (cattle, horses, and dogs) by veterinary assistants every three to six months. This was preceded by a veterinary circular issued in 1950 by the Senior Veterinary Officer.¹² From this moment, the battle against the disease took three fronts: treatment in humans, treatment in animals, and efforts to get rid of the tsetse fly.

Control measures focusing on humans in the 1950s, the final decade of British administration, consisted of repeated screening, case isolation, and treatment by teams permanently stationed in the field by the Medical Field Unit. Much work was done in the Mamfe Division where a new survey had revealed a widespread incidence of the disease. A Sleeping Sickness Superintendent at the head of four experienced junior staff was redeployed from Kaduna to Mamfe for joint work with the team on ground. Across the division, therefore, diagnosis and treatment of the disease were routinely carried out. In the entire territory, there was recourse to compulsory

attendance for examination and treatment in compliance with the new ordinance. These measures notwithstanding, Britain's report to the United Nations for the year 1952 worried about the persistence of the scourge, noting that 'There is sporadic sleeping sickness in the territory'.¹³ Subsequent reports carried this same worry, revealing the inefficacy of control measures. In 1961, the final year of British administration, the failure to eradicate human trypanosomiasis was acknowledged in the medical report. The continuing incidence of the disease was summarized in these words:

159 cases were reported; a majority of them were spotted and treated by Medical Field Unit Assistants in rural areas in all divisions. Treatment of these cases without supervision of a medical practitioner is quite unsatisfactory but due to a lack of medical practitioners nothing can be done to remedy the problem. The disease is prevalent in certain areas of all divisions and during the year the Medical Field Unit teams have gone into those areas with some success but much more remains to be done.¹⁴

The Veterinary Department was not also successful in its mission to eradicate the disease in dogs, horses, and cattle despite the sustained administration of Antrycide. The persistence of the disease in humans and animals starkly exposes the stalling nature of efforts to get rid of the tsetse fly. The latter grew in the population, with bushes and water courses remaining as breeding grounds. So, despite the fact that control measures progressively became better organized, the disease still lingered in most parts of the territory on the eve of independence. The situation thus remained worrisome as the threat of epidemic resurgence remained. While measures to prevent the disease were not going well, the treatment of infected persons and animals was promising. So, the disease persisted not because of the absence of treatment, but because of the failure of preventive measures. Sadly, treatment and surveillance structures were disrupted by the termination of the United Nations Trusteeship in October 1961 following the departure of expatriate sleeping sickness experts (Nigerians and Europeans). The burden of systematic prevention and treatment now rested on the shoulders of the West Cameroon government.

Analysing the problems on the path of control measures

To understand the persistence of sleeping sickness in Southern Cameroons despite the implementation of colonial control measures, the problems that were encountered by survey teams need to be comprehended. They ranged from colonial misconceptions, cultural arrogance, deficient human and material resources, to indigenous resistance to draconian control measures. The action around sleeping sickness control was stalled by colonial misconceptions about the disease and the local population. From the beginning, colonial

administrative and medical officials baselessly associated sleeping sickness with the lack of hygiene and sanitation, thus accusing the local population of triggering the disease. Accruing from this misconception were inappropriate control measures which were only abandoned after a chain of international conferences and research work at the Liverpool School of Tropical Medicine. But time had already been wasted and human and material resources misdirected. This had a huge bearing on how policy and practice unfolded in the territory.

Even after gaining more knowledge about the disease, European researchers fashioned control measures in a context of failure to understand or respect the territory's ecological conditions and local knowledge. This attitude hinged on European insensitivities to African local realities, described by Lyons (1992) as cultural ignorance and colonial arrogance. Out of ignorance and arrogance, colonial medical and administrative officials saw the control measures they were implementing as unprecedented, novel, and matchless. Though this claim of medical superiority is tenable, it comes close to suggesting that European colonizers came and met an indigenous population overwhelmed by the sleeping sickness epidemic. Rather, the indigenous populations had had a long history of interpreting and dealing with sleeping sickness. It has been shown that Africans were conscious of the connection between the environment and disease, especially the association between the tsetse fly and sleeping sickness. In communities across Southern Cameroons, there was awareness that the disease was common along river valleys. This explains why deliberate efforts were made not to settle in such areas before the encounter with colonialism. There was adaptation to areas where the tsetse flies were less prevalent. Though there was no microbiological understanding of the disease before colonialism, adaptation to risk-free zones suggests that the local population had knowledge of the connection between the fly and sleeping sickness. Rather, colonial investments in trade, agriculture, and infrastructure disrupted the ecological balance that Africans had maintained, thus exacerbating the sleeping sickness whose control they claimed rested solely in Western curative medicine.

Initial recourse to the curative approach by the colonial administrative and medical officials shows how out of touch they were with the traditional indigenous preventive measures. Indigenous people, though they lacked a curative solution to sleeping sickness, were conscious of the possibility of surmounting it by avoiding contact with tsetse fly-infested environments. This is a good example of how Western control measures were out of step with the knowledge indigenous people had about sleeping sickness and other diseases. This attitude is best described as ignorance expressed by Western

medics in the context of baseless claims about their medical prowess and superior civilization as a whole. Such overlooking of indigenous knowledge about the disease placed control measures on a bad course. A 1941 sleeping sickness survey report on the Mbaw area read by a colonial medical doctor carried this claim of medical superiority:

When such civic consciousness has been attained, that the people are already familiar with the conception of a survey, and have been instructed in the causes and serious effects of sleeping sickness, should greatly facilitate the more comprehensive attack on the disease which will then have become possible.¹⁵

This overlooking of indigenous knowledge and ensuing control measures was not limited to the Mbaw area. It also found expression in other parts of Southern Cameroons, especially in Mamfe Division where the incidence of the disease was highest. In communities across the division, the team ignored traditional control measures and overlooked the local medical system, telling the patients that 'No native medicine will cure the disease, and it will not stop of itself. The only cure for it is the medicine which the Doctor has.'¹⁶ This claim of medical superiority can be likened to control measures in Uganda, Rhodesia, and Belgian Congo (Courtin et al. 2008:340; Scoones 2014). This is evidence for Baronov's claim that colonial medicine was a reflection of deep racial disparities peddled by Europeans (Baronov 2008:71). By disrupting the existing ecological balance and triggering human migration into previously uninhabited zones, it became difficult to enlist the full participation of indigenous populations in the enforcement of colonially-informed measures against sleeping sickness. The draconian control policy was linked to the interests of colonial capitalism and the civilizing agenda that was built into it. Clearly, the colonial anti-sleeping sickness campaign was stalled by its dual agenda: a source of prestige and profit. It is needless then to wonder why the disease did not subside to its pre-colonial levels at the end of British colonialism.

Infrastructural challenges also stood on the path of sleeping sickness control measures. The scourge occurred in rural areas where there were no health facilities or roads. Members of survey teams made tortuous journeys to survey sites usually with an entourage of indigenous assistants. Survey teams that were stationed in localities such as Mbaw, Tombel, Sabongari, Mundame, Mundani, Fontem, and Nso lacked accommodation and did not have stations to return to at intervals. These workers were obliged to make the best of what circumstances rendered possible. Living conditions in foreign territories were difficult and abandonments were common. In Fontem, the survey team spent months in houses constructed locally with mats, palm

leaves, and sticks. To this deficient infrastructure should be added the insufficient technically and medically competent staff that was required for the enforcement of control measures. Southern Cameroons had very few medical doctors and veterinary staff to control sleeping sickness. The Sleeping Sickness Service in the Medical Field Unit at Kumba had only one specialist at the helm of a locally trained staff. Writing specifically on Kumba Division, Ebune (2016) and Ewane (2008) observe in separate studies that there was a high prevalence of sleeping sickness and other diseases in the division, attributing it to the little attention the colonial government paid to the development of health facilities. Hence the prevalence of sleeping sickness in the territory outpaced the number of workers that were engaged, with consequent pressure upon them. Such staff shortages that became even worse during the dying years of the British administration meant that the disease was left uncontrolled in some parts of the territory, in for example the Menchum Valley.

Grossly inadequate health spending was often blamed for the deficient infrastructure and personnel shortage. This was particularly in the early 1940s when the financially-demanding World War Two was ravaging Britain's economy, thus depleting already scarce financial resources. This coincided with the declaring of cyclical sleeping sickness epidemics in parts of Southern Cameroons. Prompt and appropriate action was therefore stalled by financial insufficiencies as Britain redirected funds towards her war effort. This was not good for the sleeping sickness campaign as it limited the capacity of the colonial administrative and medical staff to train and recruit medical personnel, develop necessary infrastructure, and provide drugs. It was only after the war that funds were made available from the Colonial Development and Welfare Fund for the enforcement of control measures. This was a delayed initiative as it intervened only when the disease had taken many lives.

Local native perception of control measures and resultant antipathy made the work of survey teams very challenging. Writing to the Director of the WAITR, the Medical Officer at the head of the Sleeping Sickness Service in Southern Cameroons acknowledged that the control measures were too often heeded unwillingly under the weight of perpetual coercion.¹⁷ Local resistance found expression through non-attendance at diagnosis and treatment centres and refusal to engage in community work aimed at keeping watercourses clean. The Medical Officer for Bamenda Division reported how the people of Ntem overlooked orders by their chief to clear the dense bush on the borders of the streams.¹⁸ Medical annual reports are full of descriptions of problems in persuading local populations of the necessity, efficacy, and benefits of control measures.

Taken as a whole, these problems rendered the enforcement of control measures tortuous. Measures that were taken to surmount these challenges were further marred by delays, as officials were not quick to take the initiative. Colonial administrative and medical officials were not swift in addressing difficulties at their infancy, finding solutions only when the problem had hugely escalated and this obstructed efforts at controlling sleeping sickness. Clearly, the scale, depth, and organization of such efforts were affected by these problems. As such, the disease remained a public health problem in the territory for much of the Mandate and Trusteeship periods. Plagued by these challenges, survey teams failed to reach certain parts of Southern Cameroons, thus placing patients at the mercy of death. But control measures, whether efficient or not, were a costly burden on local communities.

Imprint of control measures on local societies

The cost of colonial sleeping sickness control measures for Southern Cameroons' indigenous communities was stark. They amounted to profound disruption of the lives, practices, and beliefs of local Southern Cameroonian societies. The gravity of the disruptions produced the perception among the local population that the colonial campaign against the disease was a Western medical response in a matchless context. The attitude of the colonial administrative and medical personnel who enforced the measures was self-revealing that the local population was approached and considered as people with no knowledge of tackling the disease. Participants in the campaigns acted as humanitarians at the service of a backward people having no healthcare tradition capable of rolling away the cyclical sleeping sickness epidemics. This perception, of course, was flawed, colonially arrogant, and culturally ignorant. In his study of sleeping sickness in northern Zaire, Lyons espoused this view, describing colonial medics who designed and enforced control measures as persons who 'entirely overlooked the very considerable achievements of the indigenous peoples in overcoming the obstacle of trypanosomiasis' (Lyons 1992:3-4).

The bearing of control measures on indigenous economies was huge. The economic life of the people was undermined as they were deprived of access to food, travel, trade, and job opportunities outside their communities. In the Mamfe Division, economic stability and livelihoods for many people were threatened as they were prevented by control teams from depending on the forest for their wellbeing. In many parts of the Bamenda, Wum, and Nkambe divisions where the cattle economy had grown, the enforcement of control measures stalled the cattle trade, as local headers were not allowed to move livestock for fear of spreading the disease. The Veterinary Department

at Jakiri ensured that cattle were not moved from the Nso area to other parts of the territory, thus threatening the survival of cattle trade on which many indigenes depended. The supply of meat in some parts of the territory, especially places such as Buea, Victoria, Tiko, and Kumba dropped significantly, depriving the local population of meeting their protein requirements. Thriving long-distance trade was disrupted as the policy of controlling movements pushed traders out of business and employment. Profits on which their wellbeing rested vanished, and communities in dire need of goods they could not produce remained without them. People living along watercourses were, on some occasions, denied access to lakes and rivers. This curtailed the economic independence of groups whose livelihoods depended on fishing. Quantitatively, the hardship and ensuing deaths cannot be known, but it is true that the control measures, informed by the colonial imperative, were destructive to communal life, economically painful, and aggregately harmful to indigenous pride, wellbeing, and survival.

Conclusion

The fight against sleeping sickness in Southern Cameroons was a major preoccupation of the British colonial administrative and medical officials. Cyclical sleeping sickness epidemics threatened colonial investments, necessitating the enforcement of control measures with the intent of diagnosing and treating humans and animals as well as getting rid of the tsetse fly. Informed by capitalist ambitions, colonial arrogance, and cultural ignorance, the control measures that overlooked indigenous coping strategies were misdirected, brutal, and flawed. While control measures boosted exploitative colonial investments, they triggered low economic productivity and underdevelopment among the local populations as they were deprived of access to economic opportunities in their communities and even beyond. These ensuing phenomena were destructive to communal life, economically painful, and, aggregately, harmful to indigenous pride, wellbeing, and survival. No wonder there was local resistance to the plethora of measures that were taken to roll back the prevalence of sleeping sickness. As such, the disease remained a public health problem in Southern Cameroons, continuing into the post-colonial era, as elsewhere in the continent. Today, the Cameroon government is still battling to eradicate the disease, though its epidemiology and frequency have shrunk considerably.

Notes

1. NAB, File No. Sc (1933) 1, Sleeping Sickness and Tsetse Fly Investigation, 1933, p. 42.
2. National Archives Buea (NAB), File No. B1626, Notes on the Conduct of a Sleeping Sickness Survey in the Cameroons Province.
3. Ibid.
4. NAB, File No B1626, Letter by the Director of WAITR to the Senior Medical Officer, Southern Cameroons, 12 December 1950.
5. Post-colonial statistics reveal that 2,807 positive cases were registered in Fontem in the then Mamfe Division from 1977 to 1986 (Ghogomu, 1989:234).
6. NAB, File No. B42, Sleeping Sickness Correspondence.
7. Ibid.
8. NAB, File No. B1626, Report on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.
9. NAB, File No. B1626, Letter by Assistant District Officer of Kumba Division to the District Officer of Bamenda Division, 14 February 1941.
10. NAB, File No. B1626, Letter by Dr. T.H. Dalrymple to the Senior District Officer, Bamenda Division, 22 April 1940.
11. NAB, File No. B1626, Letter by Medical Officer to the Senior District Officer, Bamenda Division, 13 June 1940.
12. NAB, File No. AB81, Report on the Cameroons under United Kingdom Trusteeship to the Trusteeship Council, 1950, p. 126.
13. NAB, File No. AB83, Report on the Cameroons under United Kingdom Trusteeship to the Trusteeship Council, 1952, p. 96.
14. NAB, File No. B1281, Southern Cameroons Annual Medical Report, 1961, p. 7.
15. NAB, File No. B1626, Report on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.
16. NAB, File No. B1626, Notes on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.
17. NAB, File No B1626, Letter by Medical Officer in charge of Sleeping Sickness Service to the Director, WAITR, 12 December 1950.
18. NAB, File No. B1626, Notes on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.

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