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Colonial Policies and smallpox Disease control in Kabba Province, 1900-1960

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Abstract

Between 1900 and 1960, the colonial administration in Kabba Province of Northern Nigeria implemented various measures to control epidemic diseases, including vaccination campaigns, quarantines, disease surveys, specialized programs, and legislative enactments. While these interventions aimed to curb disease outbreaks, their impact was multifaceted. This paper examines the complexities of these colonial disease control measures in Kabba Province. Employing historical methods through the analysis of primary and secondary sources, the study argues that while these measures introduced modern medical infrastructure and offered some relief during epidemics, their implementation was not always culturally sensitive and often prioritized the health of European populations in urban centers. Furthermore, despite the colonial rhetoric of humanitarianism, local populations contributed financially through health taxes and disease control funds. The paper concludes that the colonial administration's efforts to control epidemics in Kabba Province had both beneficial and detrimental consequences, highlighting the crucial need for cultural sensitivity and equitable considerations in the implementation of public health measures in contemporary Nigeria.

Keywords: Colonial policies, Epidemic Disease, control Measures, impacts, Kabba Province, and Northern Nigeria.

Introduction

Kabba province, located at the Niger-Benue confluence and characterized by wooded savanna, was home to the Igala people east of the Niger River and the Igbira and Yoruba west of it. Agriculture and riverine fishing were key economic activities.[2] The province was well-watered and had diverse

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[2]Omelle, Y. B. C. "The Igala." In Z. O. Apata & Y. Akinwumi (Eds.), *The Groundwork of Niger-Benue Confluence History*. Cresthill Publishers Ltd. 2011. p 15

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vegetation.[3] Major ethnic groups included Igala, Igbira, and Yoruba, with Yoruba being most numerous in the south, Igala in the east, and Nupe in the north.[4] Originally named the middle Niger Province after British takeover, it was renamed Kabba Province in late 1901,[5] and underwent reorganizations, including a merger with Bassa in 1926 to form Kabba Province with Lokoja as its capital.[6] In June 1926, Kabba Province comprised four divisions: Igala (4,936 sq mi, 189,453 pop.), Igbira (980 sq mi, 118,087 pop.), Kabba (2,776 sq mi, 63,563 pop.), and Koton Karfe (1,690 sq mi, 8,548 pop.[7] The total area was 10,382 sq mi with a population of 411,082 in 1940, increasing from 181,557 in 1926.[8] By 1952, the population reached 663,909.[9] The province experienced recurrent smallpox epidemics, with the earliest documented case in Lokoja in 1905.[10] Major outbreaks occurred in 1906, causing many deaths,[11] and in the Bass-komo district in 1928, resulting in over 700 deaths.[12] Efforts to control the disease included public health measures, though some communities resisted.[13]The year 1937 saw further outbreaks in Bassa Nge.[14] This led to diseases control measures by the colonial administration.

While colonial administrations implemented epidemic disease control measures with the aim of managing tropical diseases and improving public health, their impacts on local populations was far from straightforward.[15] Globally, historians argue for a negative influence of colonialism on health. Neill challenges the simplistic narrative of colonial medicine as solely scientific advancement. She argues that its development as a distinct specialty was deeply intertwined with international networks and colonial power dynamics.[16] Carstairs and Mosby assert that colonial policies led to the exploitation of Indigenous people's health. They argued that healthcare service was racially provided. While non-Indigenous people were provided with healthcare services, Indigenous people were denied, and the government action was backed with the claim that the people's healthcare challenge was as a result of

[3]Upward, A. The Province of Kabba, Northern Nigeria. African Affairs, 2(VII), 1903. p. 236. doi:10.1093/oxfordjournals.afraf.a093205
[4]Omelle, "The Igala, pp. 1-12;
[5] National Archive Kaduna (NAK)/SNP 7/1850/1911/Kabba Province Summary of Principal Events. 1911. P.1
[6]NAK/Loko prof/ 1926/3712/ Kabba Province Annual Report of, 1926.p.2
[7]Ibid., pp. 1-12
[8] Ibid., pp. 1-12
[9]NAK/Lk/ 699/kadina Ministry of Justice/List of Minorities Commission.1956. P.1
[10]NAK/ SNP. 7/ 3414/Small-pox Patient Found in Lokoja Cantonment Expenses Incurred for Hut and Food and Erection of Isolation. 1905. p. 3.
[11]NAK/Annual Colonial Report (Medical Section) (1907-1908. P.7
[12]NAK / Loko Prof/ Annual Reports of Idah division, 1928. P.7-8
[13] Ibid., P.7-8
[14]NAK/Loko prof/ 467/ Igala Division Quarterly and Annual Report, 1937. P.10
[15]Tilley, H. "Medicine, Empires, and Ethics in Colonial Africa."*AMA Journal of Ethics,* 18(7), 2016. p. 743–753. doi:10.1001/journalofethics.2016.18.7.mhst1-1607
[16]Neill, D. *Networks in Tropical Medicine: Internationalism, Colonialism, and the Rise of a Medical Specialty, 1890–1930*. Redwood City: Stanford University Press. 2012. https://doi.org/10.1515/9780804781053

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their "uncivilised" nature.[17] In Africa, Lowes and Montero, and Coghe, on their part, highlights discriminatory practices, inadequate care, and the marginalisation of traditional healing systems.[18] Greenwood further complicates the picture by exposing the colonial medical service in British Africa as a multifaceted institution with diverse actors, motivations, and outcomes, moving beyond the state-driven control narrative.[19] Thus, the darker side of colonial medicine cannot be ignored. Tilley reveals how it became a tool for legitimising and perpetuating racial hierarchies.[20] Medicine, far from being neutral, served to reinforce the subjugation of African bodies and minds under the guise of humanitarianism. Chakrabarti and Worboys paint a chilling portrait of science, particularly medicine, as an active accomplice in constructing and justifying colonial rule through racialised narratives.[21] Similarly, Harrison exposes science's role in constructing and perpetuating racial hierarchies, with medicine playing a central and often insidious part.[22] While Nwashindu et al.'s study sheds light on the contradictions and limitations within seemingly benevolent public health initiatives in colonial Enugu, Nigeria, such as limited access for Africans, segregated care, and a focus on curative over preventative measures, it's undeniable that colonial medicine left a profound mark on African health and disease.[23] It introduced new concepts of disease causation and treatment, along with novel medical technologies, shaping African societies' perspectives on health and disease control even today.[24]

Kabba Province, an administrative division in Nigeria's Northern Region during the colonial era, encompassing the present-day Kogi State, and home to diverse ethnic groups like the Yoruba, Nupe, and Igala,[25] experienced these changes. Prior to colonial intervention, the province just like every other African society, had its own medical system: ethnomedicine, also known as ancestral medicine. Ethnomedicine, an integral part of African health culture for centuries, represents a desirable aspect of the people's heritage.[26] Africans, deeply

[17]Carstairs, C and Mosby, Ian. "Colonial Extractions: Oral Health Care & Indigenous People in Canada, 1945-1979" *Canadian Historical Review* 101 (2), 2020. P. 192-216.
[18]Lowes, A., & Montero, E. *The Long Shadow of Colonial Medicine: Public Health and the Afterlives of Empire*. Cambridge: Cambridge University Press.2018
[19]Greenwood, A. Ed. *Beyond the state: The colonial medical service in British Africa*. Manchester University Press. 2016. http://www.jstor.org/stable/j.ctt18dzqzf
[20]Tilley, "Medicine, Empires, and Ethics in Colonial Africa, 743–753.
[21]Chakrabarti, P., and Worboys, M. "Science and Imperialism since 1870." In H. Slotten, R. Numbers, & D. Livingstone (Eds.), *The Cambridge History of Science* (The Cambridge History of Science, pp. 9-31). Cambridge: Cambridge University Press. 2020. doi:10.1017/9781139044301.003
[22]Harrison, M. Epidemics and Empire: The Politics of Public Health in the British Empire. Oxford: Oxford University Press.2005.
[23]Nwashindu, V., Onu, A., & Okonkwo, U. U. "How public is public health?": A historical appraisal of public health services in colonial Enugu-Nigeria, 1917–1960."*Cogent Arts & Humanities*, 10(1),2023. P. 1–10. doi:10.1080/23311983.2023.2231710
[24]Cottias, M. The *Construction of Racial Knowledge by Colonial Medicine in Africa*. London: Routledge. 2007.
[25]Oshadare, O. T. "Indigenous Colonialism in Nigeria: A Case Study of Nupe Over-Rule in Okun Yoruba Land; North Central Nigeria, c.a. 1840-1897."*Port Harcourt Journal of History & Diplomatic Studies*, 7(1), 2020.p. 221-244.
[26]World Health Organization. Traditional medicine policy for Nigeria. Regional Office for Africa: World Health Publication. 2007. P.7

connected to their environment, possessed a profound understanding of natural resources and their healing properties. However, European colonisation disrupted this delicate balance, leading to ecological degradation and public health challenges. Europeans deemed ethnomedicine inferior, stigmatising and marginalising it, hindering its development for generations.[27] In its place, Western medicine became the go-to approach for epidemic diseases, justified as a necessary tool for "civilising" the continent; The superior Western medical knowledge would improve African health and ultimately lead to progress.[28]

This study add voice to the narrative that colonial medicine in Africa was not a benevolent force. I argue that British colonial government interventions were often motivated by colonial interests, leading to discriminatory practices, inadequate care, and the marginalisation of traditional healing systems. By examining the case of Kabba Province in Nigeria, this study exposes the limitations and contradictions within seemingly benevolent public health initiatives. This study delves into the complex interplay of social, economic, and political factors that shaped the British colonial administration's response to epidemic diseases in Kabba Province. I analyse the impact of these measures on the lives of the people, highlighting the disruption of traditional health practices and social structures. The findings underscore the need to move beyond simplistic narratives and delve into the complexities of colonial medicine's legacy. By centering the analysis on the experiences of the people of Kabba Province, the study aims to amplify their voices and challenge Eurocentric perspectives on colonial medicine. This research contributes to a growing body of scholarship that critiques the colonial project and its enduring impact on African health and well-being.

Disease and Healing Culture

Indigenous healthcare in pre-colonial Africa, including Kabba province, was based on three main causes of disease: natural, preternatural, and mystical.[29] This holistic system encompassed physical, mental, and spiritual well-being.[30]"Native doctors" or traditional healers like herbalists and diviners were the primary providers.[31] Their diagnostic methods, such as divination, were often dismissed by Europeans as "concoction".[32] African traditional religion provided a framework for health, believing spiritual beings and angered

[27]Ancient Origins. *Traditional African Medicine and its Role in Healing in a Modern* World. 2019. Available at: https://www.ancient-origins.net/history-ancient-traditions/traditional-african-medicine-and-its-role-healing-modern-world-004522. (Accessed 10 October 2023)
[28]Tilley, "Medicine, Empires, and Ethics in Colonial Africa, 743–753.
[29]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[30]Iroju, O. A. Understanding the Nigerian Healthcare Delivery System: A Paradox of Preventive Medicine Since the Colonial Epoch. 2018. pp. 1-9.
[31]Faleye, O. A., & Akande, T. M. "Beyond "White Medicine": Bubonic Plague and Health Interventions in Colonial Lagos."*Gesnerus,* 76(1), 2019. . p. 90–110.
[32]Orubuloye, I. O. Differentials in the provision of health services and its impact on mortality: A study of Ido and Isinbode communities in Ekiti Division of Western Nigeria (M.Sc. thesis). University of Ibadan, Ibadan, Nigeria. 1974.

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ancestors influenced well-being.[33] To cure preternatural and mystical illnesses, people used fetishes and consulted oracle spirits to identify witches.[34] Special priests, guardians of shrines, were crucial for healing those suffering from mystical causes.[35]In such cases, the diseases were only cured by special priests. The priests were the custodians of the shrines, and their role was well recognised. Okpe, describing such priests among the Igala, said:

> The Cult priests among Igala are mainly for the purposes of worship and offering of sacrifices to the deities, the Ebo. It is part of the Igala belief that certain types of bad behaviours such as stealing, lying and murder are not tolerated by the gods and the living dead. This belief, also gives the priests (atama-ebo) to bring such people to swear and be reconciled to the gods and the spirit. Thus, they are respected by the public, since they represent the gods.[36]

Across the province, traditional beliefs often link illness to the supernatural. Diseases like smallpox was attributed to curses or angered spirits, leading people to seek help from traditional healers. The Igala people of Kabba Province held a profound belief in the divine origins of smallpox, *Iye*.[37]The intricate relationship between the Igala people of Nigeria and *Iye* offers a fascinating glimpse into the rich tapestry of African ethnomedicine. This indigenous system of healing, deeply rooted in cultural and spiritual beliefs, has been employed for centuries to address various ailments, including this once-devastating disease. Central to Igala cosmology is the belief in a complex interplay between the physical, spiritual, and supernatural realms. Also, Smallpox, *Amebilo* was a dreaded disease which the Bassa people believed its cure was scarce, and as such, was prevented with variolisation, because prevention was better than cure. Thus, variolisation was common in the Bassa area of the Igala division and was potent in warding off smallpox.[38]

In other areas of the province, Smallpox, was not merely a biological affliction but a spiritual imbalance. The Igala approach to treatment was shaped by the understanding, which combined empirical observation with mystical insight.[39]The people viewed the disease as a wrathful punishment inflicted upon those who failed to honour and serve the spirits of their ancestors. This belief was deeply rooted in their ancestral worship and the intricate relationship they had between the living and the departed. According to Igala tradition, the "Atama Ebo," or spiritual guardians, were individuals chosen by

[33]Falola, T. "Culture and customs of Nigeria."*African Studies Review*, 2001. 44.
[34]Boston, J. "Medicines and fetishes in Igala." *Africa: Journal of the International African Institute*, 41(3), 1971. P. 200-207.
[35]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[36]Okpe, N. O. "The corpus of life and the phenomenon of death in a traditional Igala (African) religious society." *International Journal of Humanities Social Sciences and Education* (IJHSSE), 5(8), 2018. P. 40.
[37]Boston, Medicine and Fetishes, pp.200-207
[38]Moses Dajagar. 2024. May 06. Interview. Ethno-medical Practitioner. Sheria. 79
[39]Boston, Medicine and Fetishes, pp. 200-207;

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the gods themselves. These guardians were believed to possess exceptional moral character and a deep understanding of ancestral customs. They were tasked with maintaining harmony between the living and the spirit world. However, not every family could produce an Atama Ebo, as the selection process was rigorous and often limited to individuals from specific lineages.

Consequently, those who neglected their ancestral obligations or defied the divine will were susceptible to the wrath of the gods, which manifest in the form of *Iye*. This disease was seen as a powerful tool of divine retribution, designed to enforce compliance and maintain the delicate balance between the human and spiritual realms.[40] Resolving the imbalance was an appeasement process that involves, a public display of remorse, and then, submission of white unblemished cock which will be slaughtered to appease the ancestors, to activate the physical process of treatment and healing.[41]Mineral therapies also played a significant role in the physical process of treatment. Basalt clay, a locally sourced mineral, was widely applied to *Iye* lesions to dry them up and reduce inflammation.[42] This practice was often combined with the use of sacred herbs, water, and prayers to purify the body and ward off malevolent spirits.[43]

In Igbira area, smallpox "*Onyi-Ayi,"* or "Mother of All Diseases" was so revered that after it had infected a large number of people in a community, there was a tradition of escorting or chasing the disease out of the community. In escorting the disease, each household sweeps their dirt, and on a date set by the community leaders (traditional rulers), each member carries it to a bush where they dump and abandon the specks of dirt. People chanted and praised the disease while escorting her it and begged hit not to return to disturb them Following that, the diseases would begin to recede until it finally disappears.[44]Following which bamboo leaves *Avi Oparu,* were cure smallpox. It was typically placed in a pot with the lid firmly in place, and mud was used to seal the mouth to prevent steam from escaping. It was not boiled with water. Unadulterated palm wine was used instead of water. A cup twice a day was the recommended dosage. The patient bathes in it after drinking it. *Ireru*, or African basil, was also prepared as soup for the patient. The *Ireru* was seasoned with red oil, salt, pepper, locust beans, and bush meat. The scrap dried clay was ground and mixed with Shea butter and red oil before being applied to the patient's body. If the patient was a child, the mother of the infected child did not plait her hair during this time. If it was unplaited prior to the illness, she will not remove the hair until she recovers.[45]

In the Kabba area of the province, the Yoruba speaking area with root from the south west Nigeria, was the believed that, the *Sapanna* deity cause smallpox.[46]*Sanpanna*, was seen as a sign of divine wrath in the Kabba area. People with toxic medicines in their homes, those who mocked or angered the

[40]Omeje, S. O. Interview. Traditional chief of Umomi.100+ 2022, May 17.
[41]Ibid
[42]Enoh, W. Interview. Ethno-Medical Practitioner. 60+. 2022, May 19.
[43]Omeje, S. O. Interview. Traditional chief of Umomi.100+ 2022, May 17.
[44]Okeji C. Interview. Royal father (Idu Atami of Adavi.). Obeira. 80. 2022.
[45]Okeji C. Interview. Royal father (Idu Atami of Adavi.). Obeira. 80. 2022.
[46]Olobayo, M. O. Interview. Obaro of Kabba. Kabba.70+ 2022, May 31.

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gods, and those who frequently wore red dresses or imitated *Sanpanna*, were believed to be at risk of contracting the disease.[47] Additionally, *Sanpanna*, a revered figure, was exceptionally sensitive. He infected people with smallpox if they ridiculed him while he danced. Due to his age and physical limitations, his dancing often provoked laughter, unintentionally triggering his power.[48]To appease *Sanpanna*, the afflicted individual was expected to display a festive appearance, expressing gratitude to *Sanpanna* even in their weakened state.[49] The appeasement triggers the physical treatment, involving the extensive use of palm wine, *Ope Oti Waini*. This alcoholic beverage, derived from the sap of various palm tree species, was believed to be particularly potent when made from oil palm. The treatment regimen consisted of drinking palm wine three times a day and applying it topically to the body.[50]

In the provinces, those who diagnosed diseases were distinct from those who treated them, demonstrating early specialisation in healthcare.[51]This pattern was common across early African societies. In regions like Igbo and Yoruba territories, there was a clear division of labour between diviners, who identified the spiritual causes of ailments, and herbalists, who administered plant-based remedies.[52] However, during the colonial era, these indigenous medical systems were often disparaged and labeled as "primitive," "native," or associated with "juju medicine." These derogatory terms were imposed to align with a colonial narrative that portrayed Africa as barbaric and its people as uncivilized.[53]The advent of colonialism in Nigeria marked a significant turning point in the history of healthcare, particularly in regions like Kabba Province. The imposition of Western biomedical practices led to a gradual erosion of indigenous ethnomedical systems, a transformation that was both swift and profound.[54]

The Factors that Influenced Disease Control Approach in Kabba Province 1900-1960

The claim that Western epidemic disease control measures in colonial Africa were well-intentioned is complex.[55] While colonial administrators were concerned about disease disrupting political, economic, and social order, these

[47]Ibid
[48]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[49]Olobayo, M. O. Interview. Obaro of Kabba. Kabba.70+ 2022, May 31.
[50]Metiboba, S.. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[51]Omeje, S. O. Interview. Traditional chief of Umomi.100+ 2022, May 17.
[52]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[53]Williams, O. E. "The Politics of Labels: Imperial Categorisations and the Marginalisation of Ethnomedicine in Nigeria during the Twentieth Century."*Social History of Medicine*, 34(4),2021.p. 1297-1316.
[54]Abdullahi, L. "An African construction of colonial medicine: The Sokoto people's perception and response to the British healthcare programmes." *Sociological International Journal*, 3(5), 2019. P.362-367. https://doi.org/10.15406/sij.2019.03.00200
[55]Harrison, M. *Epidemics and Empire: The Politics of Public Health in the British Empire.* Oxford: Oxford University Press. 2005

concerns often intertwined with self-serving motives. For example, they feared disease spreading to European settlers and soldiers, who were essential for maintaining colonial rule.[56] Vaughan cites the early 20th-century epidemic disease campaign in Uganda, which expanded to include Europeans because the disease was seen as a "threat to the security of the colony".[57] This challenges the assumption that colonial public health initiatives were solely humanitarian, showing they were often motivated by a mix of self-interest, racism, and paternalism.[58]

Socially, colonial administrations feared epidemic diseases could cause widespread death and social unrest, especially since some local populations saw disease as a sign of divine displeasure and might blame the government.[59] Colonial authorities also promoted Western medicine over traditional practices, which they saw as a threat to their authority and a potential source of misinformation.[60] Traditional healers, who provided both healthcare and social support in places like Kabba province, were a particular concern for the British, who feared they might discourage people from seeking Western medical treatment.[61]

Economically, colonial governments worried that epidemics would disrupt trade and agricultural production, hurting the colony's economy.[62] Disease could lead to a decline in revenue, as money would need to be spent on healthcare instead of other public services, potentially making the colonial enterprise fruitless.[63] They also feared that epidemics would negatively impact tourism and worker productivity, further weakening the economy.

Politically, colonial administrations were concerned that epidemics could provoke political instability and anti-colonial protests.[64] They feared a large number of sick and dying people might turn against the government. Anti-colonial forces could also use disease to erode public support by claiming the government was responsible.[65] Additionally, a failure to protect the population

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[56]Vaughan, M. "The Colonial Roots of Public Health in Africa." In *The Cambridge History of Africa,* vol. 8, edited by Michael Crowder, 253-282. Cambridge University Press. 1995, p. 275

[57]Ibid., p. 275

[58]Arnold, D. " 'Civilizing' Africans: Disease Control in the British Empire, 1890-1900."*Journal of African History*, 34(2), 1993.p. 193-210.available at: DOI: 10.1017/S0021853700003827 (Accessed 20 May 2023)

[59]Falola, T. "Epidemic Disease and Colonial Administration in Nigeria, 1898-1920. " *Journal of Imperial and Commonwealth History*, 18(3), 1990. P. 313-331.

[60]Roberts, S. R. S. "The Colonial State and the Control of Epidemic Disease in Nigeria, 1900-1960."*Journal of African History*, 33(3), 1992. p. 379-400.

[61]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.

[62]Packard, R. M. "The Economic Impact of Epidemic Disease in Colonial Africa." In Packard, R. M., & Sharp, P. (Eds.), *Epidemics and Empire: The Economic Impact of Disease in the Colonial World*. Routledge. 2009. pp. 11-36.

[63]Roberts, The Colonial State, pp. 1–26

[64]Packard, R. M. "The Use of Disease as a Weapon in Colonial Africa." The *American Historical Review*, 99(1), 1994. . p. 39-69.

[65]Ross, J. C. "The Political Impact of Epidemic Diseases in Colonial Africa." *Journal of African History*, 32(1), 1991. P. 1-21.

from disease could damage the government's legitimacy and ability to govern effectively.[66] To mitigate these risks, colonial authorities implemented measures like improved sanitation, vaccinations, and quarantines to maintain political stability.

Impacts of Epidemic Diseases Control Measures in Kabba Province 1900-1960

The impact of the colonial administration's epidemic diseases control measures on the people of Kabba Province is a complex and multifaceted issue. The government disease control measures had immense impacts on the people. These impacts include racism and repression. Wilson posits that, racism is a racial dominance ideology.[67] The fact that throughout the nineteenth century, the common view in Europe was that "civilisation" was synonymous with "Europeanisation." This sense of cultural superiority prevailed even among British benefactors working for the abolition of slavery in the early twentieth century. They rarely called into question the assumption that black Africans were culturally inferior to Europeans.[68] Consequently, early European aversion to the unhealthy environment was reflected in a description of Kabba province in 1900s. According to a government report in 1912, "Kabba is a pagan province, and many of the people are among the most primitive and most backward in the protectorate"[69] Thus, the Europeans segregated themselves in the form of cantonment. Lord Lugard, the first colonial administrator of Northern Nigeria, in 1900 described Lokoja the capital of Kabba province and the first capital of Northern Nigeria thus:

> I had expressed (in former despatches) my strong conviction that Lokoja should be abandoned as an European settlement, and a site further down the river selected, where the sewage of the native town would not vitiate the water supply, where a healthier situation might be found, and the rocks, which have caused the wreck of so many steamers at Lokoja, avoided…….I have it in contemplation to gradually move the native town six or seven miles downstream, and so to do away with the pollution of the water, and with other evils such as the proximity of a haven for thieves and prostitutes, the infection of mosquitoes with malarial germs, and the insanitary conditions inevitable around a large native town.[70]

[66]Packard, R. M. *Epidemics and Empire: The Political Impact of Disease in Colonial Africa*. Duke University Press. 1997.
[67]Wilson, W. J. The *Bridge over the Racial Divide: Rising Inequality and Coalition Politics*. University of California Press. 1999.0
[68]Spitzer, L. 1968. "The Mosquito and Segregation in Sierra Leone."*Canadian Journal of African Studies / Revue Canadienne des Études Africaines*, 2(1), 52.
[69]NAK/SNP 7/ Annual Medical Report for the Year Ending 31 December 1912.p.39

[70]NAK/ SNP 7/ 1850/ Kabba Province: Summary of Provincial Events. 1911. P.6

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The quotation reveals the stark reality of European segregation in colonial Africa. The proposal to relocate the native town downstream underscores the desire for physical separation between Europeans and Africans. This was driven by concerns about water contamination, disease, and the perceived moral and social degradation of the native population. The underlying assumption was that Europeans were superior and needed to be protected from the perceived dangers of African society. This segregation, rooted in colonial cantonments, reinforced power dynamics and perpetuated the idea of racial hierarchy.

The cantonments were laid out as segregated urban spaces, designed to protect European from the perceived health risks and moral decay of the native population. While some Europeans resided within these cantonments, many others were stationed in outstations, smaller settlements located further afield. Unlike cantonments, outstations were often more temporary and less developed, serving primarily as administrative and commercial hubs. They were also strategically placed to minimise contact with the local population, further reinforcing the spatial and social divide between colonisers and colonised. They were erected on spots chosen with the assistance of medical officers. To avoid infection from latent malaria in the native population, they were placed at least half a mile from populous villages; as far away from anopheles breeding pools as possible.[71] Residential segregation along racial lines in colonial Africa was part of a larger attempt to subordinate the colonies more populous indigenous inhabitants to the dominant colonial and commercial class of administrative and settler Europeans. Thus, it was a wise use of proxemics to maintain the superordinate/subordinate connection between the rulers and the ruled. In this respect, it was a critical control tool that protected the ruling group while strengthening the indigenous peoples' position as subordinates. As a result, because the former was both biologically and ethnically superior to the latter, the ruling group had to be distinct from the submissive group.[72]

During the colonial era, race and social class were inextricably linked. Legislated residential segregation based on race was a measure that, when combined with class considerations, was dubbed "the aggregating function that allows individuals to be grouped together in objectively differentiated groupings."[73] As a result, the two major population segments were blended vertically as well as horizontally within their respective residential neighbourhoods. According to this concept, Europeans and Africans were divided into two monolithic groups, each identifiable by its area of habitation, which was decided by the colour of the inhabitants. As a result of this sort of legal segregation, the Europeans and Africans were divided into two closed groups with little geographical movement between their residential zones.[74]

[71]NAK/ SNP 7/1327/Malaria Investigation. 1903. p. 3.
[72]Alozie, B. "Space and Colonial Alterity: Interrogating British Residential Segregation in Nigeria, 1899-1919."*Ufahamu: A Journal of African Studies*, 41(2), 2020.p. 1-24.
[73]Ibid., 1-24.
[74]Ibid., 1-24.

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In the context of Kabba Province, particularly in Lokoja, this segregation took on a unique form. The impact of this division was felt deeply in the economic, social and cultural fabric of the region, shaping its history and development in significant ways. One of the most detrimental impacts of colonialism in Lokoja was the introduction and enforcement of racial discrimination. Colonialism led to an influx of Europeans into Lokoja, transforming it into a trade center, considering its status as the first colonial capital of northern Nigeria. As its characteristic, racial discrimination became rampant. For instance, the "Paparanda Bridge" served as a stark demarcation line, segregating the indigenous people's territory, referred to as the "native town," from the European quarter "cantonment". The native town was deprived of basic amenities such as electricity and pipe-borne water until the 1960s, and it lacked proper roads, except for the main thoroughfare. Furthermore, recreational facilities were conspicuously absent.[75] This stark contrast in living conditions between the European quarters and the native town is a testament to the racial discrimination that was prevalent during this period. The situation was bad. According to Amihere:

> In addition, on this was the restriction placed on the people in their own country. They were not to go beyond the bridge without permission and even then, must carry lanterns along any time after 8; clock in the evening. They were not to make noise in the European quarters and most of the roads were "no thoroughfare" roads. These restrictions were given support by the church which preached against trespassing in the colonial quarters. Thus, the people at Lokoja had a fair taste of the worst evils of European colonial rule, a situation not like what obtained in South Africa.[76]

The quotation revealed that, the Europeans restricted the movement of the indigenous people, forcing them to live in a designated area called the "native town." They were not allowed to go beyond the bridge without permission, and they had to carry lanterns at night. They were also not allowed to make noise in the European quarters, and most of the roads were "no thoroughfare" roads, meaning that they were not allowed to use them. The church was made by the government to support these restrictions, preaching against trespassing in the colonial quarters. This segregation was a form of oppression and discrimination, and it denied the indigenous people their basic rights. It was a

[75]Amihere, M. K. "Lokoja as an Important Pre-colonial and Colonial Trade Centre." In Apata, Z. O., & Akinwumi, Y. (Eds.), *The Groundwork of Niger-Benue Confluence History*, Cresthill Publishers Ltd. 2011. p. 185.
[76] Ibid., p. 185.

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stark reminder of the power imbalance between the Europeans and the Africans, and it helped to justify the colonial project.[77]

The segregation in Lokoja was not unique. It was a common practice in many parts of Africa under European colonial rule. The Europeans justified this segregation by claiming that it was necessary to protect the Africans from themselves and from the diseases that they carried. However, it was a way to maintain control over the Africans and exploit their resources.[78]The segregation in Lokoja and other parts of Africa had a lasting impact on the people. It created a sense of inferiority and powerlessness among the Africans, and it made it difficult for them to develop their own cultures and societies. Racism was evident in most activities of the Europeans. In 1904, in Zungeru and Lokoja, an enduring enclosure one acre in size and surrounded by impassable iron fencing was built to isolate smallpox.[79] It should be noted that the isolation camps were not built for the general care of the people of the province, but rather out of fear that the diseases might spread to the European areas. Commenting on the colonial disease control measures, Historian Ochonu put it aptly, "The segregation of diseased persons in early colonial Northern Nigeria reflected the morbid fear of British medical personnel about possible outbreaks of epidemic disease. The dimension it took as well as the absurdly excessive pursuit of it by colonial medical officers corresponded to the level of British anxiety"[80]

This was the reason why most of the isolation camps were established in new European settlements and towns where Europeans were many. An example was the establishment of a smallpox isolation camp in the Lokoja cantonment.[81] Also, in labour and mining camps where Europeans supervise work, it was advised to segregate all new arrivals for a period of at least one month.[82] The establishment of cantonments and outstations, and the isolation of natives in labour and mining camps was a strategic move to protect European workers from potential health risks. By segregating European staff from the local population, colonial authorities aimed to minimise exposure to infectious diseases, such as smallpox, and to maintain a sense of control and order within the labour camps. This spatial separation reinforced the racial hierarchy and power dynamics inherent in the colonial system.

Economically, epidemic disease control measures also led to an increase in old taxes and the introduction of new ones. In Lokoja, for instance, in 1906, the town council met, and approved a planned tax by the resident on April 25th of

[77]Abuh, A. A. Interview with the Kpetu of Adankolo and adviser on traditional matters to the state governor. 2022, December 22.
[78]Metiboba, S. Interview. Retired Professor of medical sociology. Anyigba. 70+. 2022, October 14.
[79]NAK/357/ SNP 7/. Annual Colonial Report (Medical Section) 1094.
[80]Ochonu, M. Native Habits Are Difficult to Change": British Medics and the Dilemmas of Biomedical Discourses and Practice in Early Colonial Northern Nigeria. Journal of Colonialism and Colonial History, .5 (1), 2004. 1-14.
[81]NAK/ SNP. 7/ 3414/Small-pox Patient Found in Lokoja Cantonment Expenses Incurred for Hut and Food and Erection of Isolation. 1905. p. 3.
[82]NAK//107/ Epidemic Celebrospinal Fever. In Epidemic and Infectious Diseases. 1925. p. 2-3.

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that year. According to the allocation, "Half will go to the government, one fourth to Mainwga, one fourth to sanitation, the money to be collected and disbursed by the ward chiefs, under the supervision of the resident in Lokoja. At a special meeting it was unanimously agreed that chief Aboga should receive a stipend of 5 pounds a month, and the ward chief 13. 14 pounds each."[83]The collection commenced in May, the average monthly take being £ 112. The sanitation expenses were as follow:

Table 1: Sanitation tax in Lokoja

Nighttime keeper and overseer	£ 5.0.0
Pappoe tax collector	£ 5.0.0
17 Town sweepers at 18/-each	£ 15.6.0
6 latrine men at 20/-each	£ 6.0.0
5 road makers at 18/- each	£ 4.0.0
Total	£ 35.16

Source: NAK, 1907. Annual Report on Kabba Province for the Year 1906. SNP 7. 1654.p.4-5

This taxation was a regressive sanitation tax, motivated by the belief that Africans lacked proper hygiene, making their environment a breeding ground for disease. This decision, rather than targeting luxury items or non-essential goods, directly burdened workers and essential commodities. Such a tax policy had a significant negative impact on income distribution, exacerbating socioeconomic disparities. The British colonial government's initiatives did not alleviate the general decline in the people's standard of living. In pre-colonial Africa, communities often had robust systems to support those in need, but in colonial Nigeria, and specifically in Igalaland, government policies exacerbated the people's suffering.[84] Despite the collection of substantial taxes, essential social services remained largely absent.[85] This led to widespread discontent, as exemplified by the 1956 Ankpa women's protest against taxation on women with no regular income.[86] Traditional chiefs, often co-opted by the colonial administration, were tasked with tax collection, increasing their power,[87] while undermining traditional systems of healthcare and governance.

Again, the British colonial administration empowered the chiefs to use force in the enforcement of health laws through the public health under Native Authorities. Conspicuous in the rule, was rule 8, which states that, 'no owner or occupier of any house or compound shall keep on his premises any well or soakage pit not properly covered and protected against the ingress of mosquitoes, nor shall he keep any thank, tub, barrel, or other vessel intended for the continual storage of water, unless the said vessel is so protected or

[83]NAK/ Annual Colonial Report (Medical Section) (1907-1908.p.4-5
[84]Omeje, S. O. Interview. Traditional chief of Umomi.100+ 2022, May 17.
[85]Abdulkadir, M. S. 'The economic history of Igalaland during the depression: 1929-1939." In Z. O. Akinwumi (Ed.), *The Groundwork of Niger-Benue Confluence History*. Cresthill Publishers Ltd.nm2011. pp. 143-166.
[86]Omelle, Y. B. C. "The Igala." In Z. O. Apata & Y. Akinwumi (Eds.), *The Groundwork of Niger-Benue Confluence History,* Cresthill Publishers Ltd. 2011. P.1-15
[87]Abdulkadir, The Economic History Of Igala, P.146

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screened as to protect access of mosquito,"[88] The rule continued in rule 10, "the native authority shall have the power to instruct the sanitary inspector, accompanied by the ward head, to inspect any house or compound in which he has reason to suspect that these rules are not being carried out."[89] The public health rule further gave the native authorities the power to enforce the rules. "Any person who hinders or obstructs the native authority in the execution of any of the provisions of Rule 10 of these rules shall be liable to a fine not exceeding one pounds, to imprisonment not exceeding fourteen days for the first offense, to a fine not exceeding five pounds, or to imprisonment not exceeding one month on a second or subsequent conviction."[90]

The provision in the law cannot be said to reward the people. The irony of these measures, however, lies in the fact that the colonial administration, while imposing strict sanitation standards, failed to provide adequate infrastructure, particularly reliable water sources. This lack of basic amenities forced many to resort to unsanitary practices, making it difficult to comply with the ordinance, and rarely report any incidence.[91] It is also germane to note that, these rules were not accepted by all colonial official. W. O. Rosedale, the resident of Kabba province in a memo to E.S Pembleton the secretary of northern provinces in 1933, states that, "The district officer 1.c Kabba division considers that the different epidemics are well known by their local names, and while he deprecate punishment inflicted under rule 9 and 10, he thinks that if touring officers were to make a point of enquiring concerning illness in all villages visited, it would tend to keep alive realisation of responsibilities in this direction and assist towards the habit of reporting becoming ingrained and a matter of routine, and I consider that this course be adopted."[92]

The quotation from W.O. Rosedale memo highlights the challenges and complexities of implementing colonial ordinances, specifically regarding disease control and reporting in the Kabba province. The quotation reveals that not all colonial officials were in favour of harsh punishments for non-compliance with rules 9 and 10. Rosedale acknowledges the local knowledge of diseases and suggests a more nuanced approach. Rosedale's proposal for regular inquiries by touring officers indicates a recognition of the importance of local knowledge and engagement. However, the colonial government's overall approach often prioritised top-down directives and punitive measures, which undermined the effectiveness of public health initiatives. Furthermore, the native authorities, empowered to enforce these rules, often exploited the situation for personal gain.[93] By fining or imprisoning those who did not comply, they enriched themselves while the underlying issues of poverty and inadequate infrastructure remained unaddressed.[94] They were designed to

[88]NAK/Loko prof. 4/284/ Kabba Province Annual Report 1926. P.4
[89] Ibid., P.4
[90]NAK/ MOH/ 159/ Vol.2/The Public Health (Northern Provinces Native Authorities' Rules. 1943. p. 6.
[91]Aduh, J. Interview with the Leper and Baale of Surulere. Oyi River. 2022, May 31.
[92]NAK / Loko Prof/65/ Public Health Under Native Authority, 1933.
[93]Abdulkadir, "The Economic History Of Igala, P.146
[94]Aduh, J. Interview with the Leper and Baale of Surulere. Oyi River. 2022, May 31.

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punish those whose actions Europeans deemed to be grossly negligent to European medicine.

The British colonialist administration also made laws that directly prohibit local approaches to epidemic diseases outbreak. Section 19 cap. 224 of the vaccination ordinance states, "Any person who shall produce or attempt to produce smallpox in any person by inoculation with variolous matter or by willful exposure to variolous matter to any matter, article, or thing impregnated with variolous matter shall be liable to imprisonment for one year."[95]Variolation is "the deliberate infection with smallpox. Dried smallpox scabs were blown into the nose of an individual, who then contracted a mild form of the disease. Upon recovery, the individual was immune to smallpox."[96] Variolation was widely practiced across Africa. Also, Ethnomedical practitioners puncture the spots of smallpox-infected people and accumulate the living pathological fluid substance. They then, in turn, transfer the fluid instance into the body of another person to build immunity against the diseases. They did this by violating the skin of the person to be infected. It could be on the back, hand, forehead, or upper arm with a sharp object. Most of those who were infected were children and young adults who had never experienced smallpox.[97]

The people adopted the above measures in the prevention of smallpox before the advent of colonialism, along with curative measures involving the combination of herbs. However, with the above European law coupled with their possession of policy, military, and weapons, the people were forced to abandon the practise and consequently, its consequences. In 1928, smallpox broke out in different areas of the province. Bassa-komo, was the district affected most. Over 700 deaths were reported by the natives.[98] This loss had tremendous impact on the people, in need of more people for agricultural production and already with a small population of 7000 in 1926.[99] 700 deaths account to over 10 percent of the population of the district. This led to decline in production of agricultural produce, and consequently rise in the price of goods. Bassa area was known for high quality agricultural produce like yam, cotton, Guinea corn, groundnut etc., which they supplied to the Igala part of the division, and other areas across the Niger. This period coincided with the great depression, and natural disaster like the yam beetle and flooding leading shortage of food supplied. In the bassa area for instance, severe flooding led to the loss of about 50 percent of total guinea corn produced in 1933.[100] The result was hunger. This led to an outbreak of *Oga Ikwu*, caused by malnutrition.[101]

[95]NAK 1929, P.361
[96]National Library of Medicine. *Variolation.*2013. Available at: https://www.nlm.nih.gov/exhibition/smallpox/sp_variolation.html. (Accessed 20 May 2023)
[97]Hayden, C. Of *Medicine and Statecraft: Smallpox and Early Colonial Vaccination in French West Africa (Senegal-Guinea).* 2008. p. 1-443.
[98]NAK/ Loko prof/4/Annual Reports of Idah Division, 1928. pp. 7-
[99]NAK/ Loko Prof/ 284/1926/ Annual Province Report 1926.
[100]Abdulkadir,"The Economic History Of Igala, P.146
[101]Ibid.,.P.146

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It is imperative to note that, such disaster did not start in the colonial era, but its impact was more in the colonial era. Historian Abdulkadir describe the situation as, "such disaster was, indeed, not new, but the realities of the colonial situation in the 1930s meant that the ability of the people to control the immediate disasters were less, while the level of their suffering increased considerable."[102]The quotation by Abdulkadir highlights the heightened vulnerability of the people during the colonial era, particularly in the face of natural disasters. While such disasters were not new, the colonial context exacerbated their impact. The decline in agricultural production as a result high of death from smallpox, coupled with economic hardships due to the Great Depression, left the population more susceptible to food shortages and malnutrition. The colonial system, with its emphasis on biomedicine and cash crop production and export-oriented economy, weakened traditional coping mechanisms and reduced the people's ability to respond to crises. The combination of death caused by smallpox, natural disasters and colonial policies, particularly the promotion of biomedicine and the undermining of traditional medicine, led to increased suffering among the population, as evidenced by the outbreak of *Oga Ikwu*, a disease caused by malnutrition.[103]

Comparing Epidemic Disease Measures Taken in Europe and Africa

The period between 1900 and 1960 witnessed a stark contrast in the approaches to epidemic diseases especially smallpox control between Europe and Africa. While European nations made significant strides in mitigating the disease, Africa, particularly under colonial rule, faced a different reality, marked by inequality, exploitation, and a lack of adequate healthcare infrastructure. In Europe, the foundation of effective smallpox control was laid upon a robust public health infrastructure. Governments invested heavily in research, leading to the development of more potent vaccines. For instance, in the early 1900s, countries like England and Germany established mandatory vaccination programs, ensuring high vaccination rates.[104] Africa, particularly under colonial rule, presented a different picture. Colonial powers often prioritised economic interests over public health, and also promotes biomedicine, resulting in a neglect of indigenous populations and healthcare. Healthcare infrastructure was limited, and medical personnel were scarce.[105] Vaccination campaigns, when implemented, were often poorly organised and lacked adequate resources. In some cases, vaccination was imposed forcefully, disregarding local customs and beliefs.[106]This coercive approach, coupled with a lack of trust in colonial authorities, hindered efforts to control the disease.[107]It is germane to note that, public health policy in Europe at this time was not static but dynamic

[102]Ibid.,.P.146
[103]Ibid.,.P.146
[104]Harris, N. *The rise of modern public health*. Oxford University Press. 2002.
[105]Tilley, "Medicine, Empires, and Ethics in Colonial Africa, 743–753.
[106]Schneider, W. Smallpox in Africa during Colonial Rule. Medical History, 53: 2009.p. 193–227
[107]Abdullahi, L. "An African construction of colonial medicine: The Sokoto people's perception and response to the British healthcare programmes." *Sociological International Journal*, 3(5), 2019. P. 362-367. https://doi.org/10.15406/sij.2019.03.00200

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depending on the disease and the area affected.[108]During outbreaks, segregation in Europe was frequently localised, transient, and focused on particular places or groups. For example, in France, during an epidemic outbreak of 1912, cordons sanitaires were erected around impacted cities.[109] During World War I, internal travel restrictions and "passports of health" were introduced to combat epidemic disease, mostly affecting refugees and underprivileged communities.[110] The immediate threat was to be contained, and social order within the established power structures was to be upheld.

In Africa, colonial segregation was often large-scale and systematic, targeting entire populations under the guise of "civilisation." Beyond disease control, measures like labour control, forced relocations, and sanitary laws were employed to exploit and oppress colonised peoples. For instance, in Nigeria's Kabba Province, hut isolation camps were established in Lokoja,[111] to contain smallpox outbreaks. British authorities also imposed travel restrictions.[112] This strategy was driven by the desire to protect the "European" populations for economic gain and reinforced by colonial notions of racial superiority.[113] A key medical tactic in African urban centers was residential segregation, or Cordon Sanitaire, which confined Africans to specific areas and restricted their access to European zones.[114] This was evident in Lokoja, where the "Preparanda Bridge" demarcated the "native town" from the European quarter.[115] These measures aimed to control the spread of disease, particularly to European residential areas. However, they also served as tools of oppression and exploitation, highlighting the complex interplay between public health and colonial power dynamics in Africa.

In Europe, the main forces behind segregation were fears about spreading disease and concerns about upholding social order. For example, patients were placed in sanatoria due to the stigma attached to tuberculosis, which frequently reflected concerns about "moral decay" and prejudices based on class.[116] Fears

[108]Tulchinsky T. H, Varavikova E. A. *A History of Public Health. The New Public Health.* 2014. .p. 1–42. doi: 10.1016/B978-0-12-415766-8.00001-X. Epub 2014 Oct 10. PMCID: PMC7170188.
[109]Hays, J. *The Politics of Disease: How Pandemics Shape Our World.* 2005. 142. https://books.google.com/books/about/Pathogenesis.html?id=C0lMzwEACAAJ
[110]Wilson, A. *The Bomb and the Body: Health, Gender, and Technology in Britain, 1865-1945*. Routledge. 2005. p. 173
[111]NAK/ SNP. 7/ 3414/ Small-pox Patient Found in Lokoja Cantonment Expenses Incurred for Hut and Food and Erection of Isolation. 1905. /p. 3.
[112]NAI/D.6.4.4/ (273/25)/ vol xi/ Yellow Fever and Smallpox Inoculation and Certificate.P.1
[113]Harrison, M. *Epidemics and Empire: The Politics of Public Health in the British Empire*. Oxford: Oxford University Press. 2005.
[114]Nwashindu, V., Onu, A., & Okonkwo, U. U. "How public is public health?": A historical appraisal of public health services in colonial Enugu-Nigeria, 1917–1960." *Cogent Arts & Humanities*, 10(1), 2023. P. 1–10. doi:10.1080/23311983.2023.2231710
[115]Amihere, M. K. "Lokoja as an Important Pre-colonial and Colonial Trade Centre." In Apata, Z. O., & Akinwumi, Y. (Eds.), *The Groundwork of Niger-Benue Confluence History*, Cresthill Publishers Ltd. 2011. p. 185.
[116]Armstrong, D. Tuberculosis and Victorian Culturep. 2010. P.25. https://books.google.com/books/about/Victorian_Culture_and_the_Origin_of_Disc.html?id=hUueDwAAQBAJ

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that typhus might spread from Eastern Europe during the war contributed to prejudice against immigrants and refugees.[117]In Africa, disease control was entwined with preexisting power dynamics and racial prejudice. To uphold colonial rule and take advantage of colonised labour, segregation was a useful tactic. For instance, in the Belgian Congo, high death rates and segregationist policies that further disenfranchised Africans were caused by forced labour practices on rubber plantations combined with poor sanitation and healthcare.[118] This strategy supported the idea that Africans were disease carriers and provided justification for their enslavement under the pretense of "hygiene." Discriminatory practices were contested in Europe by labour unions, public health activists, and even those directly affected. For instance, the "Lido" quarantine station on the Isle of Man, which primarily housed immigrant smallpox patients, faced protests from British dockworkers.[119] Medical experts advocated for improved public health infrastructure rather than stigmatisation and isolation.[120]

In Africa, resistance often manifested in individual, community, and spiritual forms, including the continued worship of ancestral spirits.[121] Ochonu stated that the people resisted the arm-to-arm vaccination in northern Nigeria, and the Mohammedans were term “passive resisters”.[122] A 1933 report from Kabba Province observed, "In sophisticated areas they are thronged with patients, but in Mohammedan and primitive districts there is less confidence in European medicine"[123] In these "primitive" areas, people often preferred ethnomedicine to European medicine, often practicing in secret to avoid colonial authorities.[124] The underlying mistrust and suspicion of the colonial regime stemmed from the shift in European-African relations from trade to conquest, subsequently colonisation, and the emphasis on shift from traditional medicine to Biomedicine.[125] Fanon argued that Africans perceived European medical practices as a tool of cultural domination and control, designed to impose

[117]Porter, D. *Medicine and the British Empire: 1900-1945.* 1994. p. 178. https://books.google.com/books/about/The_British_Empire_in_the_Middle_East_19.html?id=ATQQ0FMS1FQC

[118]Vansina, J. Being Congolese: The Experience of History in Africa. University of Wisconsin Press. 2010. P.217

[119]Porter, D. *Medicine and the British Empire: 1900-1945.*1994. p.178. https://books.google.com/books/about/The_British_Empire_in_the_Middle_East_19.html?id=ATQQ0FMS1FQC

[120]Delaunay, S. *Public Health and the Politics of Prostitution in France, 1900-1950*. Routledge. 2013. P.214

[121]Abdullahi, L. ‘An African construction of colonial medicine: The Sokoto people’s perception and response to the British healthcare programmes.” *Sociological International Journal*, 3(5), 2019. P. 362-367. https://doi.org/10.15406/sij.2019.03.00200

[122]Ochonu, M.“Native Habits Are Difficult to Change”: British Medics and the Dilemmas of Biomedical Discourses and Practice in Early Colonial Northern Nigeria.”*Journal of Colonialism and Colonial History*, 5 (1),2004. P. 1-14.

[123]NAK/ Loko prof /(No.43 of 1933)/Order Made Under the Native Authority Ordinance.1933. .P.5

[124]Omeje, S. O. Interview. Traditional chief of Umomi.100+ 2022, May 17.

[125]Abdullahi, L. An African construction of colonial medicine: The Sokoto people’s perception and response to the British healthcare programmes. Sociological International Journal, 3(5), 2019. p. 362-367. https://doi.org/10.15406/sij.2019.03.00200

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European values and beliefs.[126] This suspicion was widespread in northern Nigeria. Wada described the mistrust in Kano, noting that despite the prevalence of disease, the Kano City Dispensary, established in 1906, struggled to gain public trust due to colonial attitudes and practices.[127]

Thus, it is obvious that both Europe and colonial Africa grappled with disease outbreaks in the 20th century; the stories of how they responded through segregation reveal stark differences. In Europe, anxieties about contagion and maintaining social order fueled localised and temporary measures, often targeting specific groups or areas during flare-ups. Cordons sanitaires rose and fell around afflicted towns, travel restrictions were implemented to manage movement, and sanatoria became isolated communities for the "sick." While these practices aimed to contain the immediate threat and preserve existing power structures, they often exacerbated existing prejudices and inequalities. Across the vast expanse of Africa, colonialism painted a different picture. Segregation became a tool of both disease control and subjugation. Entire populations were targeted under the guise of "civilising" them, with sanitary regulations, forced relocations, and exploitative labour practices intertwined with public health initiatives.

This systematic approach stemmed not just from fear of contagion, but also from deeply ingrained racial biases and the desire to control and exploit the colonised. This approach made the measures to fail. Smallpox vaccination campaigns during colonial rule were a double-edged sword. Touted as one of the earliest and grandest public health initiatives by European powers, they were, in the words of a French colonial doctor, "an appreciable agent of propaganda," a shining example of the supposed benefits of colonial rule.[128] Yet, beneath the veneer of progress lay a harsher reality. These campaigns, while initially met with some success, often faltered in the face of local realities. The very communities they were meant to serve were resistant, harbouring deep-seated mistrust towards colonial medicine and its unfamiliar practices. This, coupled with logistical challenges and inadequate infrastructure, often led to patchy coverage and ultimately, failure.

The Northern Nigerian smallpox epidemic was fatally hampered from the outset by a gap between financial resources, medical efforts and mistrust. This gap suffocated all possibility of control. With limited resources, missionaries, who were frequently the only medical officers, fought valiantly and launched immunisation campaigns with unflinching determination. However, a financial system that functioned in a different reality continuously sabotaged their efforts. Due to competing priorities, bureaucratic obstacles, and budgetary restrictions, essential resources were few and frequently misallocated. Unused immunisations ran out, dispensaries were short on basic supplies, and outreach

[126]Fanon, F. A dying colonialism. In H. Chevalier (Ed.), New York Grove. 1965.
[127]Muhammad Wada, "The Spread and Impact of the Great Influenza Pandemic in Kano Emirate, Northern Nigeria 1918–1920," *Humanus Discourse* 1 (4), 2021.
[128]NAK/ (No.43 of 1933). Loko prof/ Order Made Under the Native Authority Ordinance. 1933.

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initiatives were severely hampered by a lack of money. The results of this haphazard strategy were disastrous. This mindset remained until the 1950s, when Europeans eventually admitted their system's shortcomings. According to a 1950 report:

> Small pox was very troublesome in various parts of Adamawa, Benue, Kabba, plateau and Katsina province, but the disease did not get out of hand. Concealment case and indifference rather than active resistance to vaccination resulted in the disease lying dormant in the wet season, to break out in scattered localities in the dry weather. Vaccination continued to be pressed forward, but judging form vaccination figure 10 years, and the continued presence of the disease, it would appear our method of supply, storage of vaccine, as well as actual technique of administration needs modification.[129]

Conclusion

In conclusion, the article presents a compelling argument that colonial disease control measures were racially motivated rather than the humanitarian claim of the colonisers. It posits that these measures were not designed with the welfare of the local population in mind, but rather to protect the interests of the colonial powers. The article highlights how these measures were funded by taxes levied on the local population, further underscoring the exploitative nature of colonial rule. This financial burden was not only unjust but also had far-reaching economic implications, as it diverted resources away from other critical areas such as education and infrastructure development.

Moreover, the article underscores how these disease control measures disrupted the growth of traditional medicine. By imposing Western medical practices and disregarding local health paradigms, the colonial administration undermined indigenous knowledge systems and healing practices. This not only eroded cultural heritage but also deprived communities of their autonomy in health matters. The article also critiques the narrative that portrays colonial intervention in public health as a benevolent act. It argues that this narrative is a form of historical revisionism that glosses over the racial prejudices and power dynamics that underpinned colonial public health policies.

By examining these issues through a critical lens, the article challenges us to rethink our understanding of public health history. It calls for a more nuanced and inclusive narrative that acknowledges the injustices of the past and recognises the value of indigenous knowledge systems in health. In doing so, it contributes to broader debates about decolonisation and health equity. It underscores the need for a more just and inclusive approach to public health, one that respects cultural diversity and prioritises community empowerment. Overall, this article serves as a powerful reminder of the enduring impact of

[129]NAK/ Lk/ 699/ kadina Ministry of Justice/List of Minorities Commission.1956. P.1

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colonialism on public health and the importance of addressing these historical injustices in our ongoing efforts to achieve health equity.

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