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Review Article

Sleeping Sickness Prevention in British Southern Cameroons

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Abstract

This paper explores the prevalence of sleeping sickness in British Southern Cameroons and examines the various preventive measures implemented by the colonial administration to slow down the scourge of the disease in Southern Cameroons. The disease had a deep rooted impact on the indigenous population and was recognized as public health problem in the territory. Hence there was the need to implement preventive measures against the prevalence of the disease. The British were obliged by articles 2 and 10 of the mandate and trusteeship agreements respectively to ensure the social advancement of the people. It was in this context that the colonial administration and native authorities faced with the scourge of the disease engaged preventive measures to control the disease. This explains why preventive measures including population resettlement, travel restrictions fly depopulation and bush clearing was primordial in the fight against the disease. This paper argues that preventive measures succeeded to an extent in rolling back the scourge of sleeping sickness in British southern Cameroons. Preventive measures impeded the advancement of socio-economic activities in most disease prevalent areas.

Keywords: Southern Cameroons, Sleeping Sickness, Prevalence, Preventive Measures.

INTRODUCTION

Human societies have always been faced with numerous ailments that deleteriously affect healthcare. Transcending these diseases and improving on healthcare system was a major concern for these societies throughout human history. This explains why man's history is replete with various efforts aimed at limiting the scourge of diseases. These efforts observe were fixated on specific healthcare needs, treatment of diseases, support service provision, combine research with provision of healthcare among other things [1].

The origin of tropical diseases was generally connected to social and economic conditions as well as environmental and ecological factors [2]. The existence and progress of every given society depends to a large extent on the health situation of the people. Before the advent of European colonialism in Africa, indigenous Africans crafted their own ways of managing their health challenges sanctioned by reliance on the use of natural herbs. Ndenecho contends that natural products and spiritual forces were the main mediums used in managing health problems in pre-colonial Africa [3].

Natural products involved leaves extraction, back and roots of trees and animal's parts and roots of trees. Spiritual forces involved sacrifices and incantations among other ritual observances. These systems were widely used in indigenous African societies in general and southern Cameroons in particular before the coming of the European colonial rule. Unlike other parts of the world, Cameroon was

[1] Ruth J. Prince, *Making and Unmaking Public Health in Africa: Ethnographic and Historical Perspectives*, Athens, Ohio University Press, p. 10.
[2] Jones KE, Patel NG et al., *Global Trends in Emerging Infectious Diseases*, Nature 2008;451;990-3.
[3]Emmanuel Neba Ndenecho, "Traditional Health Care System and Challenges in Developing Ethnopharmacology in Africa: Example of Oku, Cameroon", *Ethno Med*, Vol. 5, No. 2, 2011, p. 133.

faced with numerous tropical diseases like malaria, sleeping sickness, chicken-pox, leprosy, small pox among others. Hence traditional coping strategies emerged to repel the prevalence of these diseases. Though effective, the traditional healthcare system in pre-colonial Cameroon societies lacked the capacity to meet some of the health needs of the people faced with these health difficulties.

The colonization of the African continent from the 19th century onwards aggravated the prevalence of tropical diseases especially sleeping sickness by enabling its occurrence to gain a cyclical epidemiological proportion. This frequency of sleeping sickness epidemics stalled the advancement of African societies, while at the same time imposing itself as an impediment to the Western exploitative colonial agenda [4]. Colonial campaigns against the prevalence of sleeping sickness did not produce the desired results.

Theoretical Debate on Disease Control Measures

Scholars and intellectuals have debated the intentions and effectiveness of control measures against sleeping sickness, which we believe, has the potential to inform the analysis and conclusions of this study present study. In fact, observers of these control measures are sharply divided as to the intentions of anti-sleeping sickness control measures. Nisbert Machila lauds the contributions of colonialism to the fight against sleeping sickness in Zambia. He notes that the British South African Company carried out appropriate measures that were intended to contain and prevent the spread of tsetse flies and trypanosomiasis [5]. 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 [6]. While agreeing with Lyons' thesis, Biven goes further to blame European colonial intrusion and 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 [7]. In Biven's 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 to 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 sleeping sickness epidemics [8]. 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 on the trends and African responses to the disease. They contend that the campaign against sleeping sickness can only be won if the tsetse fly is eradicated.

Repeated outbreaks of the disease had an adverse imprint on demographic patterns, and thus threatened colonial investments. It was in this context that Southern Cameroons experienced Preventive efforts by colonial administrative and medical workers to contain and eliminate sleeping sickness.

Sleeping Sickness Prevalence in Southern Cameroons

Sleeping sickness is a parasitic disease unique to sub-Saharan Africa found between 15 degrees north and 20 degrees south latitude (Benenson 1995). Two protozoa subspecies, *Trypanosoma brucei gambiense* and *Trypanosoma brucei rhodesiense*, both transmitted through the bite of the tsetse fly (*Glossina* spp) cause the disease in humans. Infection with *T. b. gambiense* occurs in West and Central Africa [9].

By the time Southern Cameroons was carved into a League of Nations Mandate under British administration in 1922, disease prevalence had become a cause for concern. This was attributed to the disruption of the traditional healthcare system and the ineffectiveness of the western healthcare model introduced by the Germans from 1884 to 1916 [10]. In addition to the impact of the collision of the two healthcare systems, colonial intrusion in the territory that came to be known as Southern Cameroons, like elsewhere in Africa south of the Sahara, resulted in an increase in the prevalence of diseases, especially sleeping sickness, yaws, dysentery and venereal diseases [11].

[4] Ibid., 7.
[5] Nisbert Machila, "Trypanosomiasis, the State and Livelihoods in Eastern Province of Zambia, 1908-1964" (Masters Dissertation, University of Zambia, 2013), 12.
[6] Maryinez Lyons, *The Colonial Diseases: A Social History Of Sleeping Sickness In Northern Zaire 1900-1940*(Cambridge: Cambridge University Press, 1992).
[7] Bivens, "African Sleeping Sickness in British Uganda and Belgian Congo, 1900-1910", 45.
[8] Graboyes, Melissa. "Sleeping Sickness: Ancient Scourge, Modern Problem: Ecology and African Knowledge", *Exploring Disease in Africa: AIDS, Sleeping Sickness and Small Pox* (Boston: African Studies Centre, 2010), 1-14.
[9] Georgina Pagey, "Resurgence of sleeping sickness in Southern Sudan", Journal of Rural and Remote Environmental Health 2(2): 60-65 (2003)
[10] Asongwe, "Health Care in the British Southern Cameroons"77.
[11] ibid.

Forkusam reveals that sleeping sickness reappeared in British Southern Cameroons by 1925. The first patient recorded was a certain Nottoe who was an immigrant from French Cameroun and worked in the Guatemalan plantation company in Likomba and Elisa Esaso from Fernando Po. Within the same period, a case of a European working in the Guatemalan plantation was reported. By 1933, there were about 69 cases of sleeping sickness in Tiko alone. No enquiry had been carried out in other parts of the territory but the potential for finding cases of the disease in other towns such as Victoria, Buea, Mamfe, Kumba and Bamenda were high, and the colonial administration was aware of this possibility [12].

The prevalence was confirmed by the results of the sleeping sickness survey of 1938 which noted infected persons in the Mamfe area, Kumba, Nyasoso, Missellele, Tombel, Mbaw Plain and Esimbi and Widikum. A few years later, enquiries in these areas revealed that the incidence of the disease was worsening. Worse still, dozens of Europeans working in the plantations were affected by the disease [13]. It can be argued that by the early 1940's the incidence heightened, causing the British medical officials to announce that it had reached epidemic proportions primarily in the Victoria and Kumba divisions. The prevalence of sleeping sickness in the southern Cameroons was established thanks to the effort of epidemic survey teams that were deployed in various parts of the territory by the British administration. Liamputtong reveals that surveys were an important means of collecting health and information as far as diseases were concerned. He adds that this data and statistics collected to better strategize for preventive measures [14]. It was in this context that faced with the reemergence of tropical diseases in the territory and taking into consideration article 2 of the terms of the mandate agreement, the colonial administration sought out to carry out a survey of the sleeping sickness situation on Southern Cameroons [15].

Consequently, surveys were initiated not only by the administration but also by economic operators in the territory who reported suspected cases to the administration for action to be taken. Hence the first survey documented was carried out in 1930 following a request from the manager of the African Fruit company Carl Woermann in September 1928. In a note to the resident of Cameroons he revealed that a few cases of sleeping sickness were reported among the employees of the company's plantation in the Tiko area [16]. It was also revealed that two German employees of the plantation had contracted sleeping sickness and were under treatment in Buea in September 1928 and by 1929, the figure had moved up to five Europeans who were infected. This was indicative of the growing prevalence of the disease among the plantation personnel [17]. In 1930 a survey team was sent to the Tiko area to establish the veracity of the cases testified by the manager of the African fruit company. Consequently, Dr Williams visited Tiko to survey the area and by 1933 the prevalence of the disease in Tiko had been established.

In 1936, a survey team was sent to the Kumba division where cases were diagnosed and established among the indigenous population. It was however revealed that some of the cases were imported from French Cameroon. The medical officer for Kumba recounted in an administrative correspondence to the director of medical services in Lagos that sleeping sickness was prevalent in Laduma, Kakei, Malende and Fiango areas [18]. By 1940, a survey by Dr H. Hughes from the sleeping sickness service confirmed the prevalence of sleeping sickness in Kumba division. In the Mamfe division, the sleeping sickness survey initiated in 1939 revealed the prevalence of the disease predominantly in the Bangwa area. It was reported that in the Mundani area 36 cases were registered. In Fossung, it was reported that the disease had been prevalent in the area for more than years. The traditional ruler Tidong Mo revealed that the village registered three deaths in 1934, ten in 1936, nine in 1937, thirty five in 1938 and 1 in 1939. In Fojumeto I was reported that one hundred people died from sleeping sickness within April to august 1939. In Fotabong, three cases were reported in 1938 with one death [19].

In the Mbaw area in the Bamenda province, a survey mission led by the medical officer Le Clezio established the prevalence in the area to 5 cases. This they argued was due to the closeness of the area to French Cameroon. The area shares a boundary with the Bamum sultanate in French Cameroon and it was believed that movement from the Bamum area into the Mbaw area contributed to swell the number of cases [20].

[12] Forkusam. "The Evolution of Health Services in the Southern Cameroons under British Administration: 1916-1945", 101.
[13] File No. 621/9 Sleeping Sickness Survey.
[14] Liamputtong, P. (Ed.), Research methods in health: Foundations for evidence-based practice, 2nd Ed. (South Melbourne, Vic: Oxford University Press. 2013),1.
[15] See Neville Rubin, Cameroon: An African Federation.
[16] SC/a(1933)1, Sleeping Sikcness Victoria Division
[17] ibid.
[18] File No. SC/a(1941)2, sleeping sickness survey-Kumba
[19] File No.SC/A1958/3 investigation of an outbreak of Trypanosomiasis in Mamfe Cameroons 1938.
[20] report on the visit to the Mbaw area -Banso

In 1949, three cases were established by the survey team in the Bali Nyonga area in the Bamenda division of British southern Cameroons [21]. In 1952 one hundred and twenty four cases were reported during the field survey carried out by the epidemic team and out of this figure, seventy of them were discovered in the Befang Isimbi area in Wum Division. This was the result of a field survey by three sleeping sickness assistants attached to the survey team [22]. In 1958, the medical field unit amongst 64000 people examined and diagnosed 13 cases with the team revealing that nine out of the thirteen were established in the Bamenda division.

The main focus of the disease from the foregoing map is traced to Tiko and Misselele , the Bakossi area particularly in Nyasoso, Fontem in Lebialem under the Mamfe division , and Mamfe. These areas were largely forested areas which favored the prevalence of the tsetse fly. The area around Tiko and Misselele harbored communities along river Moungo whose main economic activity was fishing. This was leverage for frequent contact with tsetse fly given that the vegetation in this area was also dominated by mangrove. This area was also typified with plantation agriculture which attracted indigenes from various parts of the Southern Cameroons for jobs. With the population increase close to tsetse fly infested area directly led to a high prevalence of the sleeping sickness in this zone [23].

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 infectious rate was high with dramatic resultant suffering. This scourge affected every aspect of life including food production, social relations, and individual existence [24]. It was within this context that preventive measures were implemented in an effort to stem the spread of sleeping sickness.

Sleeping Sickness Preventive Measures

In an effort to consolidate the fight against sleeping sickness, the colonial administration alongside other actors initiated the preventive health campaigns which included environmental measures like bush clearing, fly control measures, population resettlement health and sanitation propaganda and disease investigation. The British colonial officials suffered severe economic losses of wide scale mortality rates of the areas labor force. They relied on the natives to provide manual labour in agricultural fields, and to transport products to trading epicenters. As a result, sleeping sickness became detrimental financially to the European colonial enterprises who had invested heavily in the Southern Cameroons.

Population Resettlement

This was one of the measures adopted by the British in an effort to implement the preventive agenda against sleeping sickness in the British Southern Cameroons. The British first introduce this approach against sleeping sickness in East Africa. It originated with Dr. David Bruce. He recommended first separating Africans from tsetse flies and then eliminating the flies by destroying their breeding places and the wildlife he thought carried the pathogen. Hesketh Bell, appointed governor of Uganda in 1906, decided on his own initiative to implement this radical idea. He ordered all Africans to move to fly-free areas two miles or more away from the lakeshore and the islands of Lake Victoria and forbade fishing and the sale or possession of fish. Hunting and gathering firewood in the infected areas were forbidden. In Bell's words, "We must withdraw from the insects the source of their infection. The whole country must be depopulated. There seems to me to be no other course than to remove everyone from reach of the fly for an indefinite period" [25].

Population resettlement is the movement of a large group of people from one region to another, often imposed by state policy or international authority and most frequently on the basis of ethnicity religion or development but also due to health challenges. Often the affected population is transferred by force to a distant region, perhaps not suited to their way of life, causing them substantial harm. In addition, the process implies the loss of all immovable property and (when rushed) of substantial amounts of movable property. This transfer was motivated by the more powerful party's desire to make other uses of the land in question or, less often, by disastrous environmental or economic conditions that require relocation [26].

This policy was an important feature of sleeping sickness policy. The topography of some areas in southern Cameroons made it difficult to relocate the population away from the tsetse fly infested areas. This was the case in the Fontem area in the Mamfe division which had a hilly terrain and made the population resettlement difficult. This area had one of the highest prevalence rates in southern Cameroons. This was

[21] Sc/a/1949 3 progress report of field epidemic team Cmeroons province.
[22] file No. SC1952/1 Medical annual report 1952.
[23] File No. SC/a/1939 SC/a(1933)1, Sleeping Sickness Tiko.
[24] Mihael Lang, "Epidemic Sleeping Sickness in British Southern Cameroons: The History of a Colonial Medical Response", 7.
[25] cited in Lyons, "*The Colonial Disease: A Social History of Sleeping Sickness*",42.
[26] ibid.

because of the subsistence life style of the indigenous people who were not self-conscious enough to stay away from the tse tse fly infested valleys and rivers, hence people simply returned to their rivers to fish and to their plantations to cultivate crops for survival. Hence this policy of population resettlement caused great hardship among the indigenes who lived and farmed near streams, river bodies and valleys and among the many fishermen who provided one of the few sources of protein for the population. Some resisted, others sneaked back to hunt or fish. As the farmers left, bush invaded their abandoned fields and so did tsetse flies [27].

Some scholars believed that one of the primary causes of the spread of sleeping sickness was the movements of the indigenous peoples in search for better socioeconomic opportunities. Some of the indigenes carried the disease vector in them which encouraged the spread of the disease as they came in close contact with the environment infested by tsetse fly in some instances. They conclude that the demographic shifts often unbalanced the delicate relations between the peoples and their 'disease environments [28].

The advantage of resettlement of the population improved the probability of the sleeping sickness teams to locate the disease carriers. As it was very difficult to locate all victims, since many indigenes were unwilling to come forward for examinations. On the other hand, many miserable victims of the disease could not manage to get themselves to the sleeping sickness team for help either because they had been abandoned by their kin or because they had been hidden away from the medical authorities by the kin. Such things could not happen after people were forced to live in areas far away from the river valleys and forests which served as habitat for tsetse flies. Consequently the sleeping sickness team could easily get to these new settlement areas to examine the indigenes [29].

In 1949, Sleeping Sickness Ordinance 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. The situation thus remained worrisome as the threat of epidemic resurgence remained. Sadly, the termination of the United Nations Trusteeship in October 1961 disrupted surveillance structures following the departure of expatriate sleeping sickness experts (Nigerians and Europeans). The burden of systematic surveillance now rested on the shoulders of the West Cameroon government [30].

Fly Depopulation Measures

Besides diagnosis and treatment by the colonialist, they were also measures aimed at eliminating tsetse flies in particular areas. The goal was to roll 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 labor, bushes along water courses were cleared, to the satisfaction of the colonial administration. In southern Cameroons, 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 [31].

The presence of tsetse flies in the territory threatened the survival of the human beings and was an obstacle to domestic animal keeping and livelihoods. However, the indigenous people knew and understood the relationship among tsetse flies, wild animal and domestic animals and the environment. Traditional traps were also used to catch the tsetse flies. The indigenous African society had indigenous knowledge systems that could prevent them against hunger and diseases. This was done as a provision for the control of the disease and prevention of the spread of the tsetse flies to other areas [32]. The indigenous community consisted of localities of dense population around which effective barriers of cleared grounds could be maintained against tsetse flies. Sometimes the land was cleared to isolate the animals from the villages near the heavily infected tsetse fly belts. Similarly those that kept cattle and livestock explored and knew these localities and evaded them during herding time as noted by R. F. Burton:

…largely by the help of fire, they cleared the land and isolated the wild animals and their accompanying tsetse flies to unattractive jungles or badlands that formed the boundary zones between the settlements of the larger peoples or tribes. The cattle keeping peoples seem to

[27] NAB, File No SC/a/1949 3 Progress Report of field epidemic team Cameroons province, NAB File No. SC/A1958/3 investigation of an outbreak of Trypanosomiasis in Mamfe Cameroons 1938, NAB File No. SC/a/(1958)3, Sleeping Sickness Survey along Kumba Victoria Divisional Boundary.

[28] Lyons, *The Colonial Disease: A Social History of Sleeping Sickness",*46.

[29] F. Courtin et al, "Sleeping sickness in West Africa (1906–2006): changes in spatial repartition and lessons from the past", *Tropical Medicine and International Health*, Volume 13, No 3. March 2008, pp 334–344 .

[30]NAB, File No. B1626, Report on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.

[31]NAB, File No. B1626, Report on the Conduct of a Sleeping Sickness Survey in the Cameroons Province, 1941.

[32]Ashu, *The Lebialem Story*,56.

have explored and known these localities and evaded them when herding [33].

Furthermore, tsetse fly eradication through creating farming fields was used as a traditional coping strategy. It is important to note that the distance that a tsetse fly covered in flying is solely dependent on the closeness of shrubs or bushes, thus the more bush clearing the less the tsetse fly can cover [34]. Therefore the people of southern Cameroons deliberately established a number of farming areas as a traditional method to control the tsetse flies and trypanosomiasis. The disease was controlled by the re-settlements of human or animal population at risk from the river valleys in the area. The environment was modified by settlement to an extent that the tsetse fly would not survive. The indigenous people also made use of the technique of smoking out tsetse flies. Fire was also used to scare off and kill the tsetse flies. The smoke from the fire in the cattle generated a very strong smell and hence acted as a repellent against tsetse flies [35].

Bush Clearing

Clearing vegetation, which tsetse use for resting and breeding, is the oldest way of reducing their populations quickly. After bush clearing, the hosts of the flies also move, thus contributing to the reduction in tsetse populations. When the vegetation reappears, however, the flies reinvade quickly. Vegetation served as habitat for different species of tsetse when the habitat is removed, tsetse flies also disappear. Clearance of vegetation was applied either by total or by removing only vegetation that was vital to the support of tsetse flies. The clearing of all woody vegetation for a few hundred yards on each side of river-crossings, and at watering-places, frequented by people was one of the earliest methods used to reduce man-fly contact and the incidence of human Trypanosoma gambiense trypanosomiasis. These clearings varied in length and were extended as a result of field observations on their efficacy under different conditions against the riverine species. This was predominant in the communities along the river Moungo which was made up of creeks and mangrove vegetation which attracted the tsetse fly [36].

There was extensive bush clearing in the Mamfe division especially around the Bangwa areas like Fontem, Fosung and Fojumeto and Kumba. Community compliance to this measure was obtained through the mobilization of the population by village headmen. Machetes for large scale bush were provided by the colonial government and the traditional rulers were tasked with the general mobilization of labour for this purpose [37]. The Chief of Ntem in the Mbaw area, received praises 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. This was how the tsetse fly habitat was destroyed in Ntem with a resultant drop in the number of infected cases [38].

It was established that in villages bush clearing was effective in rolling back the disease. In the coastal areas most especially in the Tiko area villages along the Mungo and villages situated in the mangrove zone noticed that mangrove clearing reduced the prevalence of tsetse flies in the area to an extent. It was also found that the extension of plantations also led to the reduction of tsetse fly in the infested areas which had plantations. This was justified by the clearing of forest which was a comfort zone for the fly to make way for plantations. Though it should be argued that this control measure was not intended, it was incidental given that the ulterior motive for the extension of plantation was capitalist in the context of colonial exploitation [39].

Travel Restrictions

Travel restrictions represent one of a variety of mobility restrictions imposed by the colonial administration of the British Southern Cameroons. Though carrying considerable economic and societal costs, restricting individuals' traveling freedom appeared to be a logical way to curb the spreading of an epidemic. However, whether, under what conditions, and to what extent, travel restrictions actually had a mitigating effect on the spread of disease is poorly understood. Studies have actually suggested the opposite given that in the context of this research, restrictions to movement from one area to the other and across the boundaries did not halt the spread of sleeping sickness in British southern Cameroons [40].

Travel restrictions were placed by the administration on travellers moving out of the territory towards Calabar and Fernando po. In victoria, the customs provided transport for passengers between and prior to boarding boats to Nigeria, passengers were required to provide a medical certificate which certifies

[33] R. F. Burton, ″The Lake Regions of Central Equatorial Africa″, Journal of Royal Geographical Society, XXIX,.1.

[34] John Ford, The Role of Trypanosomiasis in African Ecology: A study of the Tsetse Fly Problem (Oxford: Oxford University Press, 1971), p.234.

[35] Atabong Mary, interview by Ngwe Fondikum Naah.

[36] NAB File No.SC/a(1933)1, Sleeping Sikcness Survey Tiko.

[37] NAB, File No. B1626, Letter by Medical Officer to the Senior District Officer, Bamenda Division, 13 June 1940.

[38] NAB, File No.B1626, Letter by Medical Officer to the Senior District Officer, Bamenda Division, 13 June 1940.

[39] NAB, File No.B42, Sleeping Sickness Correspondence.

[40] T. P. Velavan and C. G. Meyer, "The COVID-19 epidemic," *Trop. Med. Int.* Health **25**, 278 (2020).

that there were free from infecting the sleeping sickness staff. Some of these shipping lines were managed by the UAC implemented this preventive measure to ensure that passengers were sleeping sickness free [41]. The two main testing centers were based in Victoria and Tiko which were port cities. This measure was reinforced by a correspondence from the district officer in February 1937 who recommended that any person suffering from the disease should be prevented from embarking from any ports in the division. This was motivated by declaration of sleeping sickness as an infectious disease [42]. Though by March 1937, the medical officer for victoria prescribed that passengers should only be allowed to embark from victoria for purpose of easy control [43].

Similarly, by December 1937, same measures were implemented in Muyuka where indigenes that had planned to travel out of the area were expected to present medical certificates as evidence that they were free from sleeping sickness. In this light, the medical officer carried out fortnightly visits to Muyuka with the aim of examining intending travellers for sleeping sickness [44]. The target for this campaign was for the population who intended traveling to French Cameroon. Only after this examination could the indigenes travel to their destination (French Cameroon). After the medical examinations, the clerk of Muyuka attached the results to a *laissez passer* which was forwarded to the district officer and in return, a health certificate was issues which enabled the indigenes who were not tested positive to travel to French Cameroon. It is appropriate to note that intending travellers who did not go through this procedure had to wait for a fortnight for the medical officer. This was an effort to control the spread of the disease beyond the boundaries of British southern Cameroons [45].

Challenges

Some challenges were faced in efforts to implement disease preventive measures against sleeping sickness in the British southern Cameroons. 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 preventive measures stalled cattle trade as local headers were not allowed to move livestock for fear of spreading the disease [46].

The Veterinary Department at Jakiri ensured that cattle did not leave 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 from meeting their protein requirements. Thriving long distance trade was disrupted as the policy of controlling movements knocked 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 in lack. Communities living along water courses were, in some occasions, denied access to lakes and rivers [47]. This curtailed the economic independence of groups whose livelihoods depended on water resources most especially in the coastal forested part of the territory. From the foregoing, it was difficult for the indigenous population to adhere to the aforementioned restrictions which severely affected their socio-economic life. The population needed time and sensitization to accept the restrictions on their economic activities. This slowed the pace of the implementation of preventive measures against the sleeping sickness in the territory [48].

Insufficient financial resources, to promote the implementation of preventive measures against sleeping sickness became a serious setback. In the 1920s when the healthcare system was designed by the British and approved for implementation, its blueprint could not be fully executed due to the lack of finances. It was earlier noted that the general assumption was that Britain's colonies should be largely self-supporting, principally through funds generated by local taxation imposed on indigenous populations. Added to this is the fact that Southern Cameroons was governed as an integral part of Nigeria, with no budget of its own. This meant that the fight against tropical disease in the territory had to be covered by finances allocated for healthcare in Nigeria [49]. This insufficiency in funding, placed the fight against sleeping sickness on a slow pace .The passing of the Colonial Development Act in 1929 could not roll back these financial difficulties that were

[41] NAB File No 292/MedS.P/25 letter from senior health officer southern provinces to the director of medical and sanitary service Lagos.

[42] NAB File No V.361/202 sleeping sickness control: question of declaration as an infectious disease.

[43] NAB File No 648/101/33, memorandum from the medical officer Victoria to the senior resident Buea.

[44] NAB File No 72/11, sleeping sickness health certificate 1938-1938.

[45] NAB File No V.361/218 letter from District office Victoria to the District Head Muyuka.Sleeping Sickness

[46] John Ford, The Role of Trypanosomiasis in African Ecology: A study of the Tsetse Fly Problem (Oxford: Oxford University Press, 1971), p.234.

[47] File No V.1453 Field Unit (epidemic team) Cameroon province.

[48] NAB, File No. B1281, Southern Cameroons Annual Medical Report, 1961.

[49] NAB, File No. Ba/1935/4, Annual Medical Report 1955.

stalling the medical sector. The already bad financial situation, it should be noted, was made worse by the economic recession of the 1930s whose impact on the British economy was devastating [[50]]. Due to the aforementioned financial difficulty it was challenging to fully implement sleeping sickness preventive measures in the territory.

The indigenous perception of the disease was a major challenge in the implementation of disease control. In most communities in Southern Cameroons, sleeping sickness was associated to tradition. The indigenous people of southern Cameroons perceived that sleeping sickness was caused by witchcraft and poison. This was common in the indigenous African context where witchcraft was also associated with social tensions within the clans and capacity of elders and sorcerers to curse a person and bring sleeping sickness over them. Sacrificial rituals were usually carried out in order to cleanse the infected person from the sleeping sickness. This was usually done by the indigenous traditional authorities. It was difficult to convince the indigenous population that the disease was not linked to sorcery [[51]].

Prior to western medicine, the traditional African society had its own interpretation regarding the prevalence of sleeping sickness in communities. With the advent of western medicine, this perception was gradually eroded given that colonialists put in place preventive measures to combat sleeping sickness in the territory. Though, it is germane to note that such traditional beliefs still remained rooted in the minds of some indigenes though this could not be scientifically proven. It was possible for indigenes to be cursed mystically with the disease. Some commented that this association was common before health information was brought to their knowledge by the curative campaigns initiated by the colonial authorities [[52]].

CONCLUSION

Preventive measures against sleeping sickness in British Southern Cameroons, was a major concern to the colonial administrators and medical officials. The work has examined the prevalence of sleeping sickness in British southern Cameroon as a whole. The different preventive strategies adopted by the actors involved in the fight against sleeping sickness in British southern Cameroons. These preventive services fashioned the overall healthcare policy in the territory took the form of population resettlement, bush clearing, health campaigns and movement restriction. All these measures were aimed at eradicating the disease in southern Cameroons. These preventive strategies educated the population on prevention and the dissemination of the necessary environmental and healthcare practices that were adopted. The preventive measures created health awareness among the population though in the context of poor funding and poor health infrastructure, the British found it difficult to eradicate the prevalence of sleeping sickness through preventive measures.

[50] Asongwe, "Healthcare Delivery in Southern Cameroons' ,276.
[51] Ngwe , "Sleeping Sickness in Fontem",59.
[52] ibid.

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