Summary. This article examines the role of African chiefs in the administration of colonial medicine in rural south-western Nigeria, emphasising the adaptive ways they navigated a difficult position between colonial medical authorities and indigenous medical legitimacy. Whereas colonial authorities expected chiefs to enforce medical policies and to encourage their subjects to use medical facilities, Africans wanted chiefs to defend and promote Yoruba medical and religious practices that colonial authorities and missionaries usually undermined. By supporting established African healing systems, chiefs stood to gain political mileage and favour with traditional healers. Furthermore, we argue that although African chiefs cooperated with the government in implementing health policies, they had a difficult relationship with sanitary inspectors who enforced sanitary regulations in ways that bred resentment. In the 1940s, Yoruba chiefs advocated for more rural health services, perhaps to pacify the rising nationalist movement that would have made them irrelevant had they not cooperated.

Keywords: Healthcare southwestern Nigeria; Chiefs - Southwestern Nigeria; colonial health services Nigeria; health services Nigeria; rural healthcare Nigeria

Introduction
Since Eric Hobsbawm and Terence Ranger’s *Invention of Tradition* thesis, there has been a flurry of scholarship examining the inventions of African identities, evolving political societies and questions of chieftaincy in colonial bureaucracies.¹ This thesis has undergone reformulations as a result of criticisms by subsequent scholars who highlighted the limitations of the colonial state in the inventive process and how ‘invented traditions’ were constantly reconstituted and given new meanings.² These rejoinders complicate

¹Terence Ranger, ‘The Invention of tradition in Colonial Africa’, in Eric Hobsbawm and Terence Ranger, eds, *The Invention of Tradition* (Cambridge: Cambridge University Press, 1983).
²A few examples include, Benedict Anderson, *Imagined Communities* (London, Verso 1991); Anthony D. Smith, ‘The Nation: Invented, Imagined, Reconstructed?’., *Millennium*, 1991, 20, 353–88; Thomas Spear, ‘Neo-traditionalism and the Limits of Invention in British Colonial Africa’, *Journal of African History*, 2003, 44, 3–27; Olufemi Vaughan, ‘Chieftaincy Politics and Communal Identity in Western Nigeria, 1893-1951’, *The Journal of African History*, 2003, 44, 283–302; Jocelyn Alexander, *The Unsettled Land: State-making and the Politics of Land in Zimbabwe 1893-2003* (Athens: Ohio University Press, 2006); Enocent Msindo, *Ethnicity in Zimbabwe: Transformations in Kalanga and
conventional understandings of what seems like a smooth transaction of power within colonial landscapes by exploring the complex and diverse agendas pursued by African chiefs during the colonial era. In certain instances, these studies explore chiefs’ legitimization and mobilization agendas, rooted in practices that complicated colonial authorities’ imaginations of traditional political authority.3 Yoruba chiefs provide a classic example by deploying their imaginations of traditions and indigenous political structures in dealing with issues of healthcare and other everyday rural administrative challenges.

The weaknesses of the colonial state provided the possibility for African chiefs to articulate alternative meanings to colonial imaginations. Chiefs took advantage of the administrative and financial limitations of the state to assert some control, albeit limited, over rural health service delivery. This enabled them to claim their legitimacy, power and prestige that emanated from them playing the colonial middlemen role.4 However, for the chiefs to meet the expectations of their subjects, they tried to adapt colonial policies to their local contexts. This process turned colonial locales into sites of complex power dynamics and political struggles, especially in areas on the margins of colonial administration.

By its very nature, (yet without overt intent) indirect rule colonialism left room for chiefs to exercise some limited measure of administrative discretion and flexibility on how they control rural Africans.5 Consequently, some chiefs took advantage of indirect rule to entrench patronage networks. In some instances, chiefs suppressed African healers that did not concede to this patronage system and their personal interests.6 On this point, Mamdani is correct in arguing that African chiefs exhibited characteristics of ‘decentralised despots’, conveniently positioned in power as colonial ‘customary’ authorities.7 Chiefs were convenient in rural areas because of the relative ease in assimilating them into the colonial bureaucracy.8 They provided medical intelligence about the nature and pattern of endemic and epidemic diseases, which European colonialists could not easily obtain.9 However, chiefs were not always, or merely hegemonic rural despots. Rural communities were sites of contestations of ideas and politics that fostered wide ranging interactions between rival groups.10 Moreover, kinship and kingship institutions

Ndébele Societies, 1860-1990 (Rochester: Rochester University Press, 2012).

3Spear, ‘Neo-traditionalism’, 3–27. See also, Olufemi Vaughan, Nigerian Chiefs: Traditional Power in Modern Politics, 1890s-1990 (Rochester, 2000), 210-211.

4Thomas Spear, ‘Neo-traditionalism and the Limits of Invention in British Colonial Africa’, Journal of African History, 2003, 44, 3-27.

5Bruce Berman, “Bureaucracy and Incumbent Violence: Colonial Administration and the Origins of the ‘Mau Mau’ Emergency”, in Bruce Berman and John Lonsdale, Unhappy Valley: Conflict in Kenya and Africa, Bruce Berman and John Lonsdale, eds. (Oxford: James Currey, 1992), 232; Webel, ‘Medical Auxiliaries and the Negotiation of Public Health’ 393-416.

6Kapya John Kaoma, ‘African Religion and Colonial Rebellions: The Contestation of Power in Colonial Zimbabwe’s Chimurenga of 1896-1897’, Journal for the Study of Religion, 2016, 29, 57-84; Karen E. Flint, Healing Traditions: African Medicine, Cultural Exchange, and Competition in South Africa, 1820-1948 (Ohio: Ohio University Press, 2008)

7Mahmood Mamdani, Citizen and Subject: Contemporary Africa and the Legacy of Late Colonialism (Princeton: Princeton University Press, 1996), 21-3, 4.

8Lonsdale, Unhappy Valley, 209; B.E. Kipkorir, ‘The Functionary in Kenya’s Colonial System’, in B.E. Kipkorior, ed., Biographical Essays in Imperialism and Collaboration in Colonial Kenya (Nairobi: Kenya Literature Bureau, 1980). For justifications on African chiefs’ collaboration with European colonialists, see, Semakula Kiwanuka, From Colonialism to Independence: A Reappraisal of Colonial Policies and African Reactions, 1870-1960 (Nairobi: East African Literature Bureau, 1973).

9Webel, Medical Auxiliaries and the Negotiation of Public Health, 393-416.

10Fred Cooper, ‘Possibility and Constraint: African Independence in Historical Perspective’, The Journal of African History, 2008, 49, 167-196; 171.
had divergent, yet collective societal obligations and agendas. These included the need to provide services to those subjects who were invested in and agitated by the slow pace of colonial reforms.\(^{11}\) The challenge was how chiefs would fulfil these dual-mandates while operating as colonial middleman.\(^ {12}\) In some places, chiefs tried to defend community interests from government’s dictates.\(^ {13}\) Thus the responses of chiefs to colonial bureaucratic interests were not uniform.

This study illuminates the diverse and contrasting ways that Yoruba chiefs negotiated roles and responsibilities within the provincial health bureaucracy. Their integration into colonial service delivery system was not a smooth process. Colonial administrators had to force it to work because it was financially and administratively expedient.\(^ {14}\) It empowered chiefs to raise money to support missionary controlled hospitals and other rural health services. Chiefs also were expected to encourage their subjects to patronise western medicine and to control unregistered indigenous healers. Through the 1901 colonial ordinance, authorities in Lagos reorganised chieftaincy by ascribing paramount chieftaincy to two traditional figures—the Alaafin (king) of Oyo and the Ooni (king) of Ife while relegating some others to subservient status as ‘non-royal’ chiefs (the baale).\(^ {15}\) This rupture of the pre-existing political structures ignited violent episodes in the region as ‘lesser’ chiefs fought for recognition.\(^ {16}\) This ultimately impacted on health and healing services as they became sites for power struggle, with some subordinated chiefs not fully cooperating with medical authorities in protest against their demotion.

Our argument contrasts with developments in other non-English colonies and even in English colonies that were under direct rule. In French West African territories, chiefs played very minimum roles with regards to rural healthcare delivery. French district administrators restricted the participation of African chiefs in rural healthcare to very passive roles.\(^ {17}\) In Portuguese colonies like Guinea, Angola and Mozambique, chiefs were appointed to participate in healthcare delivery and disease control only in the event that an European administrator ‘enjoyed a rather questionable reputation’.\(^ {18}\) French and Portuguese approach were a result of their assimilationist administrative policies.

\(^ {11}\) Reuben Loffman, ‘An Interesting Experiment: Kibangile and the Quest for Chiefly Legitimacy in Kongolo, Northern Katanga, 1923-34’, International Journal of African Historical Studies, 2018, 50, 461-477; 462.

\(^ {12}\) Nicole Eggers, ‘Authority that is Customary: Kitawala, Customary Chiefs, and the Plurality of Power in Congolese History’, Journal of Eastern African Studies, 2020, 14, 24-42.

\(^ {13}\) See generally Jocelyn Alexander, The Unsettled Land: State-making and the Politics of Land in Zimbabwe 1893-2003 (Athens: Ohio University Press, 2006).

\(^ {14}\) T. C. McCaskie provides instance of how the British adopted indigenous institutions due to their viability during the precolonial period. See, “Anti-Witchcraft Cults in Asante: An Essay in the Social History of an African People,” History in Africa 8 (1981), 125-54. See A.E. Afigbo, ‘The Warrant Chief System in Eastern Nigeria: Direct or Indirect Rule?’, Journal of Historical Society of Nigeria 3, 4 (June 1967), 683-700; J.A. Atanda, The New Oyo ‘Empire’: A Study of British Indirect Rule in Oyo Province, 1894-1934 (Ph.D Thesis, University of Ibadan, 1967); Obaro Ikime, ‘Reconsidering Indirect Rule: The Nigerian Example’, Journal of the Historical Society of Nigeria 4, 3 (December 1968), 421-438.

\(^ {15}\) Vaughan, ‘Chieftaincy Politics and Communal Identity in Western Nigeria’, 283–302, 287.

\(^ {16}\) Ibid., 284–302.

\(^ {17}\) Elise Huillery, ‘History Matters: The Long-Term Impact of Colonial Public Investments in French West Africa,’ American Economic Journal: Applied Economics, 2009, 1, 176-215; 181.

\(^ {18}\) Philip Jan Havik, ‘Public Health and Tropical Modernity: The Combat against Sleeping Sickness in Portuguese Guinea, 1945-1974’, Historia, Ciencias, Saude-Manguinhos, 2014, 21, 641–66, 660.
British indirect rule gave native authorities power to collect taxes from villagers. These taxes were used for everyday rural administration; medical services; education; infrastructure development, and for other purposes. Indirect rule functioned through ‘... a chain of district and rural village heads, with a system of native courts, police and prisons under their own control and paid for from their Treasuries’.\(^\text{19}\) Although Northern Nigeria had long exposure to indirect rule from the onset of colonial rule, Southern Nigeria became formally exposed to indirect rule after 1914. In some parts of the South-western Nigeria, however, the principles of indirect rule were already being contemplated and were partially applied in the centralised Yoruba kingdoms of Abeokuta, Oyo, Ife and Ondo before indirect rule was fully implemented in the rest of the region.\(^\text{20}\) In these areas, chiefs were largely hereditary and enjoyed considerable powers over huge areas. When it was formally preferred after 1914 in the southwest, indirect rule faced serious implementation challenges up to the late 1920s due to many factors—and this impacted on the state’s ability to implement health policies in the region in those years. Firstly, unlike in the Northern Territories where Muslim Emirs ruled over-centralised Islamic kingdoms,\(^\text{21}\) in the South-west, numerous clans and chiefdoms did not easily submit themselves to the authority of bigger, centralised chieftaincies that had already embraced indirect rule. There was also no unifying religious ideology as the South was a mixed bag of Christianity and traditional religions. So it took long for indirect rule to be fully implemented and this was done in stages years after the Native Authority Ordinance of 1916 (which provided the legal basis for a fully-fledged indirect rule system,) was promulgated.\(^\text{22}\)

Secondly, the region’s historical exposure to educated elites and political activism meant that the powers of chiefs were challenged as demands for service delivery became more pronounced. Third, it was difficult to collect taxes in these Yoruba areas because, ‘... although there existed tributary relationship between the kings and their subjects they were not accustomed to the organization of their treasury in a systematic manner.’\(^\text{23}\) Finally, some chiefs did not cooperate with government on policy enforcement and on other issues. These were often deposed and replaced by acquiescent ones. Deposing difficult chiefs did not help in the short term as people questioned the legitimacy of new imposed chiefs, ultimately impacting on those chiefs’ ability to govern and to deliver services. For instance, for five years, the government failed to control a powerful Chief Eshugbayi, the head of the House of Docemo close to Lagos, who openly disobeyed government orders. When Eshugbayi was eventually deported in 1925, he was replaced by a pliable chief, Ibukunle Akitoye as the Eleko. This new Eleko struggled to control the people who opposed his chieftaincy.\(^\text{24}\)

Elsewhere, many more chiefs were deposed for, ‘... persistent attitude of

\(^{19}\) Colonial Annual Reports, London, No. 1842: Annual Report on the Social and Economic Progress of the People of Nigeria, 1936, p. 4.

\(^{20}\) Annual Report on the Social and Economic Progress of the People of Nigeria, 1936, p. 7. See also, Lord Harleigh, ‘British Native Policy and Administration in Tropical Africa’, paper presented to the Witwatersrand Branch of the South African Institute of International Affairs, 1941, 5.

\(^{21}\) British House of Lords Sitting, Hansard 1, 1803-2005, ‘Native Administration of Nigeria’, 17 December 1924.

\(^{22}\) Enyi John Egbe, ‘Native Authorities and Local Government Reforms in Nigeria since 1914’, Journal of Humanities and Social Sciences, 2014, 19, 113–27.

\(^{23}\) Ibid., 116.

\(^{24}\) Nigeria, Colonial Annual Report for 1925, 10.
obstruction to Government authority and policy. 25 On Empire day in 1926, the Eleko was waylaid and beaten up by an organised mob on his way from the Race Course. 26 Some villagers in Owo of Ondo Province (who forcibly took away the chief’s insignia to show that they did not recognise him) and those in Ngi and Ngonu of Bamenda division and others, were reported to be recalcitrant, riotous and ungovernable so much that they were only controlled by force of arms. 27

The first section of this article traces the period up to the early 1920s where we highlight the role of early African medical doctors; medical missionary work in rural areas and, the establishment of the West African Medical Service. The second section explores the formal introduction of chiefs to rural medical services and how chiefs generally received this initiative. We then discuss the ways chiefs interfaced with sanitary inspectors, illustrating their keenness to control the activities of such inspectors so as to entrench their power over rural health services. Although they worked within Native Authorities and were also paid from Native Authorities funds, sanitary inspectors were recruited, trained, deployed and were largely answerable to the Provincial Health Officers, where they could lay complaints against chiefs or anyone who obstructed their course of duty. 28 Lastly, we examine the chiefs’ attempts to regulate indigenous healers, and how these efforts demonstrated the chiefs’ growing politics of patronage.

Missionaries, WAMS and Early African Medical Doctors before the 1920s

From the turn of the century to the late 1920s, there were neither comprehensive nor clearly pronounced state interventions and policies on health on the margins of colonial administration, especially in south-western Nigeria further away from Lagos. There were some state initiatives such as environmental sanitation, land reclamation, construction of drainages, drug distribution and vaccination. However, these were implemented in Lagos and in a few other major city centres such as Abeokuta, Akure, Ijebu and Ibadan where there were a few white settlers and black labourers who serviced the colonial economy. Outside these areas, government had left the health of Africans to missionaries who had long established mission stations, most of which had rudimentary medical services. Many rural dwellers travelled long distances to access health facilities in town and at these mission stations. 29

Among wide-ranging justifications for this metropolitan focus is the fact that the colonial expedition into Nigeria and early attempts to do missionary work in Nigeria since the 1860s had been disastrous as many colonial officers, missionaries, and health officials struggled to adapt to what they labelled ‘the extremely harsh diseased environment’. 30

Before the advancement of tropical medicine, very few white medical doctors were
willing to relocate to this ‘disease environment’, choosing rather to concentrate in European settlements. In saying this, we are not assuming that there were no doctors who ever served in rural areas at all during the Crown colony phase (1861) and even after the declaration of Nigeria as a British Protectorate (in 1901). We merely emphasise that there was no real colonial policy to establish a robust medical service before 1920. The early authorities that administered Nigeria before it became a Protectorate recruited black West African students for training as medical doctors in prestigious British institutions.\footnote{Adelola Adeloye, ‘Some Early Nigerian Doctors and their Contribution to Modern Medicine in West Africa’, \textit{Medical History}, 1974, 18, 275–93.} These African medical doctors such as William Davies (1858), Africanus Horton (1858), Nathaniel King (1874), Obadiah Johnson (1884), John Randle (1888), Orisadipe Obasa (1891) and Akinsiku Leigh-Sodipe (1892) became the first black doctors to practice in West Africa, serving in the medical services up to the late 1920s.\footnote{Ibid., 275.} Some of them, like the Kings College trained doctor, Nathaniel King served as a missionary doctor in Lagos where he played a leading role in improving sanitation in the early 1880s.\footnote{Ibid., 277–78.} Obasa led the Governor’s smallpox vaccination scheme in Lagos and Ekiti, his district of origin.\footnote{Ibid., 278.} Some of them wrote books on tropical medicine, African therapeutics and natural medicine that informed early thinking on indigenous health systems. Others established private medical practices and dispensaries in Lagos.\footnote{Ibid., 282–90.}

Unfortunately, after 1901, colonial authorities did not work with this generation of medical doctors to develop broad-based rural healthcare systems. They side-lined African doctors from the newly amalgamated West African Medical Service (WAMS). Recruitment of doctors into WAMS was characterised by racial discrimination as only doctors with European parentage were enlisted into the medical services.\footnote{Patton, \textit{Physicians, Colonial Racism, and Diaspora in West Africa} (Gainesville: University Press of Florida, 1996).} Secondly, it was difficult for non-Europeans to meet the requirements for recruitment into WAMS which included diploma certification in tropical medicine from the London or Liverpool School of Tropical Medicine. As very few West African doctors could meet this requirement due to a lack of sponsorship to study in England, they were technically and tactically disqualified from becoming members of the WAMS.\footnote{See Ryan Johnson, “An All-white Institution”: Defending Private Practice and the Formation of the West African Medical Staff’, \textit{Medical History}, 2010, 54, 237-254.} The British colonial office created an entirely different roster for African and Indian doctors, restricted them to subordinate cadres, and limited the numbers recruited to the colonial medical service. Adell Patton argued that this development was the consequence of nineteenth-century scepticism within the British Medical Association about the potential advancement of African doctors in medical practice.\footnote{Ibid., 282–90.} He illustrated instances when the association lobbied the colonial office to create an entirely different portfolio for African doctors. At the dawn of the twentieth century, the colonial service had substantially reduced the African staff of the medical service and had restricted the few Europeans within the service to city centres.
The above partly explains why there were very limited WAMS officials to facilitate health services in rural areas. Before 1930, the burden of rural health was largely left to medical missionaries. Although medical missionary work had commenced in Nigeria by the 1890s, they were however limited by financial, ideological and environmental challenges. Their services were inadequate to cater for Africans outside the mission’s sphere of influence. Medical missionary work in Nigeria were pioneered by two Roman Catholic organizations—Society for African Missions and Our Lady of Apostle who established Sacred Hearts, the earliest rural hospital in Abeokuta in 1895. Till the 1930s, the Catholic mission in Abeokuta lacked professional medical practitioners. Consequently, their medical work was administered by amateur nuns who merely provided very rudimentary services. The reason for this, according to David Hardiman, was that the Catholic Church banned members of religious orders from studying medicine. Hence, most of the nursing sisters had no training in medicine; they relied on mere common sense and faith in dealing with the sick.

Like the Roman Catholics, Protestant missions also faced enormous problems in rural areas. From 1927, they often applied to government for grant-in-aid support. The American Baptist Mission and the Wesleyan Methodist Missionary Society were also involved in medical missionary work in Ogbomosho and Ilesa where they established a few hospitals. By 1927, there were three missionary hospitals and about ten dispensaries in south-western Nigeria. These were inadequate for growing rural populations as they were concentrated in very few communities. These facilities had a very few qualified medical staff and a limited supply of drugs. Narrating his experiences, Dr Jays, who in 1904 was stationed in Abeokuta told an audience of medical missionaries and auxiliaries in Holborn that he often served over 150 people a day at the dispensary. He left Abeokuta ill, was not replaced, and the dispensary closed.

Unlike missionary medical work that existed in some rural areas before the 1920s, colonial medical service was either woefully inadequate or virtually non-existent in most rural areas. Government was hopelessly disconnected from rural areas so much that they did not even have ways of getting accurate birth and death records should the chiefs not report these to the district officials. Colonial administrators complained of the lack of strong centralised polities with wider geographical reach, noting that existing several small chieftaincies made it difficult to administer as there was no guarantee that all the chiefs supported government’s administrative processes, including

39 See Edmund M. Hogan, Cross and Scalpel: Jean-Marie Coquard among the Egba of Yorubaland (Ibadan: HEBN Publisher, 2012).
40 David Hardiman, ‘Introduction’, in David Hardiman, ed., Healing Bodies, Saving Souls: Medical Missions in Asia and Africa (Amsterdam, New York: Rodopi B.V., 2006), 24.
41 NAI, CSO 26/2/19963, vol. 1, Deputy Director of Medical and Sanitary Service to Chief Secretary, 28 December 1927.
42 NAI, CSO 26/2/19963, vol. 1, ‘Grants to Control Medical Missions in Nigeria’, Director of Medical and Sanitary Service to Chief Secretary to the Government, 11 October 1927.
43 NAI, CSO 26/2/19963, vol. 1, Deputy Director, Medical and Sanitary Service to Chief Secretary, 17 October 1927.
44 Adedamola Adetiba, The Tropical Environment and Malaria in South-western Nigeria, 1861-1960, Unpublished PhD Thesis, Rhodes University, RSA, 2019, p. 90.
45 Preaching and Healing, 1905, London, Church Missionary Society. Available through: Adam Matthew, Digital, CMS, Periodicals, http://0-www.churchmissionarysociety.amdigital.co.uk.wam.seals.ac.za/Documents/Details/CMSCRL_Preaching_1905-1906_01 [Accessed May 22, 2018], p. 27.
health administration.\textsuperscript{46} We quote at length the 1904 report of H. Bedwell, the Acting Secretary of Old Calabar, which articulates his frustrations of dealing with uncooperative African communities.

Diplomacy may win a point here and there, but in the person of the Administrative Officer it is often sent, unless supported by a strong escort, flying out of a town somewhat quicker than it entered it. By this means \textit{[by diplomacy – emphasis added]} new areas are opened up; the intentions of Government are explained; the worst barbarisms indulged in are required to be put an end to; and the official concerned proceeds to another town convinced, is he is a new hand, that the people will do everything that they have promised. Visit after visit may follow – but certain as day follows night comes a time when the native no longer pretends to believe in the power of the white man’s government, which apparently only possesses, at one time, one white official and thirty soldiers \ldots The areas are not yet under control, where slave dealing, human sacrifices, juju observances, and inter-town warfare still go on unchecked, amount to rather more than one-fourth of the total area of the Protectorate. A considerable portion of the remainder is still in a very unsettled state \ldots Patient work and time will do much with the native, but only when he is in constant contact with the European. Given sufficient European supervision (emphasis in original text), the work done, and to be done, will the more easily be consolidated and made firm and lasting.\textsuperscript{47}

Although there was a general policy of segregation that privileged Europeans in accessing health services,\textsuperscript{48} colonial medical services were not properly organised. This was also the case in the rest of West Africa. Noting the disjointed manner in which medical services operated in West Africa, the Chamberlain regime started schools of tropical medicine in London and Liverpool—and from these emerged the need for a coordinated medical service system which was put in place in 1902 as the WAMS. The role of WAMS was to recruit white medical officers to serve in West Africa; to administer, and to train medical personnel in six medical departments in British West Africa so as to make British West Africa healthier and more inhabitable.\textsuperscript{49} WAMS, which existed between 1902 and 1914, was dogged by many challenges and plans to revamp it were affected by World War I. During its years of operation, WAMS facilitated medical research in West Africa, particularly in setting up research laboratories in Lagos and elsewhere.\textsuperscript{50}

WAMS operations were inhibited by many challenges mainly due to the chaotic nature of colonial health services. It was inefficient; underfunded; suffered due to bad working relations of medical officials and their superiors, and due to the self-interests of medical officials.\textsuperscript{51} Moreover, medical ideas from tropical schools did not easily permeate through

\begin{footnotesize}
\textsuperscript{46}Colonial Annual Report No. 433 for Southern Nigeria, 1903, (London, 1904), p. 24, 39. \\
\textsuperscript{47}\textit{Ibid}, p. 41. \\
\textsuperscript{48}Annual Medical and Sanitary Report for the Nigerian Colony and Southern Provinces, 31 December 1917, p. 13. \\
\textsuperscript{49}Helen J. Power, \textit{Tropical Medicine in the Twentieth Century: A History of the Liverpool School of Tropical Medicine, 1898-1900} (London: Kegan Paul International, 1999); Ryan Johnson, ‘The West African Medical Staff and the Administration of Imperial Tropical Medicine, 1902-14’, \textit{The Journal of Imperial and Commonwealth History}, 2010, 38, 419-439. \\
\textsuperscript{50}\textit{Ibid}, 426. \\
\textsuperscript{51}\textit{Ibid}, 419-439.
\end{footnotesize}
colonial locales as colonial doctors often viewed metropolitan scientists as intruders who lacked the understanding of local contexts.\textsuperscript{52} WAMS did not transform the plight of rural areas in south-western Nigeria as it remained an elitist entity that used West Africa as a field from which they collected specimen for purposes of imperial medical knowledge. Most of its medical staff (seventy-four medical officers, including four black doctors, and two sanitary inspectors in 1910) served the predominantly white population in the Southern Protectorate specifically Lagos, Port Harcourt, Enugu and Ibadan. There was also a very high staff turnover due to deaths, illness, transfer to other countries and resignations.\textsuperscript{53} The same lack of support for Africans in rural areas was also evident in the Northern Province where Cameron Blair, a sanitary officer lamented the state of the African health crisis saying,

\[ \ldots \text{I seldom enter a native town particularly a native town near any considerable Township or station to which a Medical Officer is posted without thinking of how little we do for the Indigenous Natives. It is exceedingly sad to see the services of the Medical Officers almost completely monopolized by employees of the government and by African and other Non-European, as well as Europeans, Aliens: the indigenous Natives being well-nigh entirely left out in the cold.} \textsuperscript{54} \]

Key changes took place in the late 1920s as government sought to control medical services in rural areas. The approach was twofold. The first shift was in giving support to missionary hospitals as government reasoned that missionaries were worth supporting for their experience of delivering rural medicine.\textsuperscript{55} Supporting missionaries also opened the possibility of them cooperating more with the colonial regime. From the late 1920s to the 1940s, government used African treasuries to financially support rural medical missionary health centres. Government hoped that advancing this support would enable missionaries to train African medical staff to work under their supervision.\textsuperscript{56} The second intervention was the use of chiefs and their rural structures to control existing small medical services and to develop further rural health facilities. The rationale was that African chiefs would, through their Native Treasuries fund the construction of rural dispensaries and hospitals; disseminate public health propaganda, and sanction sanitary offenders. This system, it was envisaged, would lead to some form of African administered medical service. This was an attempt to control the many African hospitals and clinics under some kind of uniform structures headed by native authorities. Here, government sought to control the rural health services sector through chiefs, yet without funding them from

\textsuperscript{52}Douglas Haynes, ‘Social Production of Metropolitan Expertise in Tropical Diseases: The Imperial State, Colonial Service and the Tropical Diseases Research Fund’, \textit{Science, Technology and Society}, 1999, 4, 205-238; Joseph Hodge, \textit{Triumph of the Expert: Agrarian Doctrines of Development and the Legacies of British Colonialism} (Athens, OH: Ohio University Press, 2007).

\textsuperscript{53}Southern Nigeria, Annual Report on the Medical Department, 1910, p. 1.

\textsuperscript{54}NAI, CSO 26/2/15216, Scheme for Preventive Medicine and Hygiene in Nigeria, Cameron Blair to the Principal Medical Officer, 26 January 1919.

\textsuperscript{55}NAI, CSO 26/2/19963, vol. 1, Grants to Control Medical Missions in Nigeria, Deputy Director of Medical and Sanitary Service to Chief Secretary to the Government, 13 August 1927.

\textsuperscript{56}NAI, CSO 26/2/19963, vol. 1, Deputy Director of Medical and Sanitary Services to Director of Medical and Sanitary Services, 28 December 1927.
the central budget.\textsuperscript{57} This move to control rural health was premised on the assumption that epidemic diseases from rural areas would potentially undermine the colonial economy and European settlement.\textsuperscript{58} Rural Africans were viewed as diseased bodies that could endanger towns due to frequent migrations across the divide.\textsuperscript{59}

Placing such facilities under local authorities was financially expedient to colonial administrators in Nigeria as was the case elsewhere. Writing about health and society in Kenya, George Ndege believes that health policies that recognised local authorities in Kenya helped to ease the colonial government of the financial burdens that accompanied the provision of social services to rural areas.\textsuperscript{60} British social policies during the interwar years in indirect rule colonies were in tandem with their political and economic realities.\textsuperscript{61} They could not afford a capital-intensive projects during the economic depression between the World wars.\textsuperscript{62}

Reinventing Medical Traditions through African Chiefs

Before 1914, south-western Nigeria was administered under a mix of direct rule around Lagos and its vicinities, and some form of indirect rule through a few traditional chieftaincies outside Lagos. Although the Lagos Colony was merged with the Protectorate of Southern Nigeria in 1906, and although from 1914, the government made concerted efforts to assert greater influence in the South, government’s overall control of Yorubaland remained weak. This is because some Yoruba communities in the hinterland still did not have a fully functional native authority system until 1928. Therefore, the efforts, from the early 1930s to use chiefs and their Native authorities, to fund rural health systems happened at a time when the very native administration structures were barely established. This was in contrast to Northern Nigeria where indirect rule was preferred from the onset. By 1936, there were still many kingdoms of south-western Nigeria that had not yet organised themselves to meet the demands of the indirect rule system, and some did not trust their native authorities.\textsuperscript{63} The emergence of educated elites complicated the situation as some of them preferred new, more radical political formations in their engagement with the colonial state.\textsuperscript{64} Earlier (in this article), we alluded to compelling evidence of villagers who disobeyed colonial chiefs; chiefs that defied government, and also the generally chaotic and slow uptake of indirect rule in south-western Nigeria.

By using African authorities to enforce health policies in rural areas, the colonial regime hoped to increase their control over rural health and developments in rural communities. Caught in between, chiefs bore the brunt of poor rural service delivery protests. They also faced criticism for their despotic tendencies in rural communities. On the other

\textsuperscript{57}NAI, CSO 26/2/15216, Cameron Blair to the P.M.O. 26 January 1919. See also George Ndege, \textit{Health, State and Society in Kenya} (Rochester: University Press, 2001), 128.

\textsuperscript{58}Glen Ncube, ‘Robert A. Askins and Healthcare Reform in Interwar Colonial Zimbabwe: The Influence of British and Trans-Territorial Colonial Models’, \textit{Historia}, 2018, 63, 62–92.

\textsuperscript{59}NAI, CSO 26/2/15216, Cameron Blair to the P.M.O. 26 January 1919.

\textsuperscript{60}Ndege, \textit{Health, State and Society in Kenya}, 128.

\textsuperscript{61}See for instance the ambitious social policies of the Portuguese in colonial Angola, Samuel Coghe, ‘Reordering Colonial Society: Model Villages and Social Planning in Rural Angola, 1920-1945’, \textit{Journal of Contemporary History}, 2016, 52, 16–44.

\textsuperscript{62}Ndege, \textit{Health, State and Society in Kenya}, 128.

\textsuperscript{63}Annual Report on the Social and Economic Progress of the People of Nigeria, 1936, 1938, p. 8.

\textsuperscript{64}Ibid.
hand, by virtue of the shortage of colonial officials to monitor native authorities in the discharge of their responsibilities, government unwittingly played into the hands of chiefs, who manipulated the system to their advantage and entrenched their politics of patronage in rural areas.

Chiefs were not necessarily new to issues of medical services. What was new is the way colonial authorities expected them to relate with their people in the process. Chiefs were expected to collect taxes to fund rural infrastructure, including dispensaries and hospitals, subject to the approval of the Resident Commissioners. They were also charged to control traditional healers. Chiefs also disseminated rural health propaganda and interact with visiting health officials. In the pre-colonial era, and arguably after the colonisation of Nigeria, among Yoruba chiefs, kingship institutions operated within a system that ascribed to kings and chiefs the responsibilities for social cohesion, security, and wellbeing. Such a system, according to Emmanuel Idowu, was termed ‘diffused monotheism’ in which the Olodumare (the Supreme Being) empowered the oba (king) to protect his people from disasters and sicknesses. The popularity and symbolic importance of the institution of the Oba was contingent on how best power was utilised for communal wellbeing and prosperity. However, the oba relied on priests and healers for legitimacy and for assistance in community health and wellbeing.

This situation was not exclusive to Nigeria, but was also the case elsewhere in Africa. In precolonial southeast Tanzania, Malawi, northern Mozambique, Zimbabwe, Zambia, and south eastern Zaire, Gloria Waite argued that there existed well established public health systems that regulated the conduct of cleansing, rainmaking ceremonies, identification of sorcerers, control of infectious diseases, health education and public sanitation. These created possibilities for kings, priests, ministers and councillors to find a common meeting ground. Whereas Chiefs derived their powers from material and military support in their chiefdoms, healers had large, trans-territorial networks that gave them considerable power and some independence from chiefs. Besides their in-depth knowledge of physiological and spiritual realities, a healer’s power was contingent on his mobility across diverse polities. In the course of traversing trans-regional landscapes, healers accumulated enormous knowledge and power.

In the early colonial era, and up to the late 1920s, chiefs interacted with medical missionaries in their communities, giving them permission on where to set up medical centres. They also interacted with early African medical doctors who researched in rural

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65S.O. Okafor, ‘Ideal and Reality in British Administrative Policy in Eastern Nigeria’, African Affairs, 1974, 73, 461.
66Emmanuel Bolaji Idowu, Olodumare: God in Yoruba Belief (London: Longman, 1962), 57–106.
67Roland Hallgren, The Vital Force: A Study of Ase in the Traditional and Neo-traditional Culture of the Yoruba People (Lund: University of Lund, 1995), 74.
68Gloria Waite, ‘Public Health in Precolonial East-Central Africa’, in Steven Feierman and John M. Janzen, eds, The Social Basis of Health and Healing in Africa (Berkeley: University of California Press, 1992), 212–31.
69David Maxwell, Christians and Chiefs in Zimbabwe: A Social History of the Hwesa People, 1870s-1900 (Edinburgh: Edinburgh University Press, 1999).
70Jean Comaroff, ‘Healing and Cultural Transformation: The Tswana of Southern Africa’, Social Science and Medicine, 1981, 15, 367–78; Anne Digby, ‘Bridging Two Worlds’: The Migrant Labourer and Medical Change in Southern Africa’, in Robin Cohen, ed., Migration and Health in Southern Africa (Cape Town: Content Solutions, 2004), 18–26.
71Interview with Oba Adebobola Josiah, (the Asarun of Isarunland, Isarun, Ondo State, Nigeria), July 15, 2018.
areas and set up medical practices. In this time, chiefs also reported to the colonial administration on births and deaths in their rural communities. However, up to this point, there was no clear policy that specified their roles in rural health services. This changed from the early 1930s. As leaders of the reconstituted native authorities, chiefs took up more responsibilities like encouraging some reluctant people to patronise medical facilities within their localities instead of preferring traditional healers. In 1925, a colonial officer lamented that ‘... the aversion of the greater part of the population to European medicine is a heavy handicap’ to the efforts to provide prophylaxis against widespread relapsing fever and ‘cerebro-meningitis’.73

Chiefs were also obliged to cooperate with sanitary inspectors and to ensure the people’s observance of antimalarial programmes, chiefly bush clearance and filling of disused pits.74 They were empowered to use draconian laws to enforce health protocols. As far back as the 1920s, the Collective Punishment Ordinance ascribed responsibilities of social order to chiefs. Using these laws, colonial officials often held a whole village responsible, and invariably punish them for crimes committed by any of its members. Chapter 80 of the 1926 ordinance stated:

The Governor may impose fines on all or any inhabitants of any village or district of members of any tribe or community if, after inquiry, he finds: That they have wilfully disobeyed, or neglected or refused to carry out, any lawful order given to them by an administrative officer or by a native authority. That their conduct has been such as to require the bringing of soldiers or police to the village or district or the employment of soldiers or police against them to prevent or suppress disturbances or enforcing lawful orders or the payment of taxes leviable under any law of the Protectorate.75

The Collective Punishment Ordinance was applied whenever local authorities tolerated cultural traditions and practices proscribed by the state. The state, for instance, frowned at any chief that permitted the worship of Sopona deity as such worshippers opposed anti-small-pox campaigns. The Sopona cult, presided over by the ‘... the Priesthood of the Small-pox God’ was an established practice that they illegalised through a 1910 law.76 In the 1920s, the provincial authorities at Abeokuta invoked the Collective Punishment Ordinance on the Chief of Ipokia and Akinloye, the chief of Ilaro because they worshipped the Sopona deity in their communities.77 This law and other anti-juju and anti-witchcraft laws were applied with a view to repress African priests and indigenous healers. Under the Nigerian Criminal Code of 1948, chiefs were obliged to report any person involved in illegal voodoo activities.78 It prescribed a minimum sentence of three years to any chief who ‘... directly or indirectly permits, promotes, encourages or

72Adeloye, Some Early Nigerian Doctors, 275–93.
73Nigeria, Annual Colonial Report for 1925, p. 11.
74NAI, MN/C2, The Principles of Native Administration and their Application, Lagos, Government Printer, 1934.
75National Archive Enugu (hereafter NAE) EP 6784, CSE 1/85/32624, Inquiry under the Collective Punishment Ordinance, 2.
76Southern Nigeria: Annual Report for the Medical Department, 1910, p. 2.
77NAI CSO 26/3/21055, Abeokuta Province Annual Report, 1924.
78S. 211, Criminal Code, Chap. 42, ‘Laws of Nigeria, 1948’. 
facilitates ... the worship or invocation of any juju which has been prohibited by order of the council’. Effectively, this turned acquiescent chiefs into despotic colonial native constables.

Chiefs featured in these newly prescribed roles in diverse ways. In certain instances, they interacted with colonial officials and medical missionaries in recommending funding for rural medical missionaries and on extending medical facilities in their villages. By the 1930s, government general hospitals, the African Native Administrations run dispensaries, and medical mission hospitals and clinics were severely strained in their capacity to deliver medical services in rural areas. Government control over African dispensaries was weak as they did not have medical officers in most rural areas. Rural populations’ patronage of hospitals and dispensaries had increased. The number of Africans who visited general hospitals in Nigeria increased from about 85,237 in 1910 to 517,497 in 1931. Between 1931 and 1934, the numbers increased from 517,497 to 642,502. These figures exclude those who received treatment at the 226 dispensaries that were managed by African Administrations. In 1933 alone, a total of 628,065 patients were treated at these African dispensaries.

With increased patronage of medical centres, rural church-based medical facilities were overstretched at a time financial support from their sending churches in England was declining due to the depression of the 1930s which triggered financial stringency at home and in the mission field, and in some cases closure of some of the missions. Facing this financial crisis, medical missionaries appealed to the government for grant-in-aid support from native authorities. Correspondences between medical missionaries and government authorities in south-western Nigeria show how desperate missionaries lobbied government to authorise native authorities to fund missionary hospitals. Following their consultations with native authorities, government usually approved these requests under certain conditions, particularly that the missionaries would extend their medical services into the sponsoring communities. In 1936, the Church Missionary Society was awarded £150 per year for five years on condition that it opened a hospital at Ado-Ekiti. In February 1939, the Methodist mission proposed stationing a European nursing sister either at Ikole-Ekiti so that she would travel to supervise dispensaries and do other medical work in the districts of Ikole, Ado, and Ijero under the supervision of a visiting District Medical Officer, based at Ilesha. The proposal was approved after due consultation with all the districts concerned. The Methodist mission was awarded a grant-in-aid of £250 for the 1939–40 financial year on condition that the proposed nursing sister will also visit and supervise African dispensaries in the area. We see here a culture of consulting African chiefs and how native Authorities supported the extension of medical missions in their districts.

79 Ibid.
80 Annual Report of the Medical Department, Lagos, 1910, p. 1; Nigeria Colony: Annual report of the Medical and Health Services for 1934, p. 6.
81 Ibid.
82 Terence Ranger, “Taking on the Missionary’s Task”: African Spirituality and the Mission Churches of Manicaland in the 1930s’, Journal of Religion in Africa, 1999, 29, 175–205, 176.
83 See correspondences in this folder: NAI, M.L.G (W) 1/18245, The Acting Resident, Ondo Province to The Honourable Secretary, Southern Province, 4 March ‘1940.
84 NAI, M.L.G (W) 1/18245, The Acting Resident, Ondo Province to The Honourable Secretary, Southern Province, 21 February 1939.
For chiefs and their local structures, this move by medical missions was about increasing medical support in their marginalised communities. For government however, it was about conveniently using money from the Native Authorities to support missionary medicine as a way to increase government control of medical work in the further parts of the province. The Acting Resident of Ondo Province was clear that the seconding of a European Nursing Sister to the districts, ‘... would solve the difficulties of supervision and I consider that the offer has come at an opportune moment.’ The Lagos based colonial administrators simply used native authorities system to control rural medicine that they would ordinarily not have been able to. Missionaries believed that their churches would grow if they transform the African mind-set in terms of their use of medicine. They believed that since African medicine was based on superstition and worship of non-Christian deities, medical missions were therefore an integral part of their evangelism. For medical missionary work to grow, missionaries needed to gain the support of chiefs in convincing Africans to patronise Western medical therapies.

In south-western Nigeria, chiefs’ courts frequently hosted missionaries and colonial medical officers. They also served as rudimentary clinics for potential patients. Local chiefs used local resources and institutions such as their messengers to disseminate information about medical officers’ visits and to ascertain that people attended medical outreaches that they (the chiefs) organised. For some non-hereditary chiefs, having been imposed by the colonial regime, their positions depended largely on their ability to balance the needs of their employer as well as to placate their community members. They strove to be seen to be agents of development without destroying established healing traditions. In a bid to compete with rival communities, chiefs were called upon by their people to support medical missionaries. In Ilesha, the king provided land for the Wesleyan Methodist hospital and the residence of the medical missionaries. The native administration also provided an annual disbursement to the Methodist missionaries to support their medical work. In 1939, the council disbursed £950 from its treasury to construct maternity health facilities at Ilesha, and in Ora, a small town in Oyo province.

As chiefs were warming themselves in their new positions, they soon faced the pressure from the emerging African nationalist movements of the 1940s and 1950s. African nationalism promised alternative leadership and radical reforms. Consequently, some chiefs were responsive to the changing political context. In this period, the Olubadan (chief of Ibadan) received complaints about a lack of maternity clinics in rural areas, as protesters complained about the overconcentration of health facilities in urban Ibadan.

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86 Ibid.
87 Hannington Ochwada, ‘Western Biomedicine and Colonialism: The Church Missionary Society Medical Mission in the Lake Victoria Basin’, in Toyn Falola and Emily Brownell, eds, *Landscape, Environment and Technology in Colonial and Postcolonial Africa* (New York: Routledge, 2012), p. 124.
88 Interview with Chief Ajipe (the Elegrin of Isarunland, Ondo State, Nigeria), 19 July, 2018. See also Shankar, ‘Medical Missionaries and Modernizing Emirs’, *The Journal of African History*, 2007, 45–68.
89 Ibid.
90 C. A. Pearson, *Front-Line Hospital* (Cambridge: FSG Communications, 1996); F.D. Walker, *A Hundred Years in Nigeria* (London: Cargate Press, 1942), 108–12.
91 NAI M.L.G (WV)1/18245, Vol. 1, Waterworth to White, 4 January 1941.
92 Ayo Ladigbolu, *The Roots of Methodism in Ibadan Diocese* (Lagos: Akintayo Printers, 1996), 100.
93 NAI IBADIV 1/1/382/22/11, Minutes of Ibadan (Provisional) District Council: Health, Rural Development and Social Welfare, 21 March 1950.
About five hundred women stormed his palace complaining that they were denied treatment at the congested Adeoyo hospital. Facing these protests, some chiefs wrote petitions to the government describing the everyday health challenges of their subjects. In 1938, the Warri native council reported about the state of infant mortality, complaining that hospitals were located too far from their villages. They requested that a doctor be scheduled to visit them fortnightly. The government responded by instructing a senior medical officer to visit the division monthly pending the improvement of road networks in the area and on condition that African council provided accommodation to the medical doctor.

By the late 1940s, the native court negotiated with medical doctors on ways to address rural healthcare issues. In response to public demand for rural maternity clinics and the decongestion of urban general hospitals, state officials converted the Adeoyo Hospital, the first government-owned hospital in Ibadan, into a referral maternity hospital. New rural maternity centres were also established, all linked to the Adeoyo hospital. The Olubadan’s council however had a different view. It opposed the move to convert the main hospital in Ibadan town into a maternity hospital. They instead wanted bigger hospitals to be built in rural areas, arguing that rural areas had the most dire need of hospitals than urban areas. They also recommended that concerted efforts be put towards establishing many rural maternal clinics.

Along this line of thought, the Council supported the establishment of domiciliary midwifery centres across rural areas outside Ibadan for people that could not access Adeoyo Hospital. Local chiefs viewed domiciliary midwifery policy as means to decentralise the health system so as to accommodate semi-skilled African health workers. These workers would be trained in midwifery by missionary nurses and thereafter deployed to rural areas as domiciliary midwives. In general, the training of other health officers, chiefly African dispensers, chemists and medical assistants had already started at Yaba Medical Training Centre near Lagos in the late 1920s. However, the midwifery training only began after rural protest and representations from the chiefs. In Ibadan, the Council appointed Mrs Leeming of the CMS to facilitate the implementation of the midwifery training scheme. Similarly the native administration in Abeokuta appointed Miss McCotter to train domiciliary midwives. The domiciliary midwifery policy also provided

94NAI IBADIV 1/1/1221, vol. 4, Native Administration Hospital, Adeoyo, Minutes of the Health, Rural Development and Social Welfare Committee, 6 July 1956.
95NAI CSO 20/23610/S.756, Petition for Medical Facilities in Urhobo Division, Warri Province, Urhobo division to the governor of Lagos, 21 March 1938.
96NAI CSO 20/23610/S.756, Petition for Medical Facilities in Urhobo Division, Warri Province, Ag. Director of Medical Service to the chief secretary to the government, 30 April 1938.
97Overloading of the Maternity Department of Adeoyo Hospital, The Southern Nigeria Defender, 8 May 1956.
98NAI IBADIV 1/1/1221, Native Administration Hospital Adeoyo, District officer to Olubadan-in-Council, 25 November 1949.
99NAI IBADIV 1/1/1221, Ibadan District Council Hospital Adeoyo, A.H.C. Walker to C.P. Murray, 23 October 1949.
100NAI IBADIV 1/1/1221, Native Administration Hospital Adeoyo, Minute of the Ibadan Native Authority Divisional Council Meeting, 26 April 1950.
101Annual Report on the Social and Economic Progress of the People of Nigeria, 1936, p. 21.
102NAI IBADIV 1/1/382/22/11, Ibadan District Council, Minutes of Ibadan District Council: Health, Rural Development and Social Welfare, 7 June 1956.
103NAI CSO 26/2/11875, vol. XVII, Annual Report of Abeokuta Province, 1950, 17.
training for traditional birth attendants (TBAs) so they could operate within conventional health systems in rural areas. Going through a formal training legitimised and formalised TBAs. Those who were trained would operate without the risk of being arrested by government. They also claimed knowledge of both traditional and western birth practices and this gave them competitive advantage over those who were not registered. \(^{104}\) By the early 1950s, chiefs continued to support missionary hospitals. Their treasuries also funded public rural hospital construction. They had also learnt to deal with the challenges of service delivery under growing rural political protests and women activists who demanded greater access to maternity facilities.

**Chiefs, Sanitary Inspectors and the Politics of Rural Health**

African chiefs had to deal with other intricacies of rural health politics, especially in the light of the rising importance of rural sanitary inspectors since the 1920s. The relationship between chiefs and sanitary inspectors demonstrate the ways in which the former sought to protect their rural political space by controlling the health related activities of the latter. They did so by claiming that they were protecting the rural folks from the alleged excesses of sanitary inspectors. Some chiefs entrenched politics of patronage over the rural populace at a time their popularity was supposed to be on the wane.

Ordinarily, chiefs were expected to work closely with sanitation superintendents at the province and the sanitary inspectors in implementing health policies. They were also obliged to create an environment for sanitary officers to operate unhindered. Within this official structure, African chiefs were subordinates of provincial government. According to the Public Health Ordinance and the Destruction of Mosquitoes Ordinance, sanitation superintendents formulated sanitation measures while native administrations simply enforced such policies. \(^{105}\) Although auxiliary employees (in this instance, sanitation inspectors) assisted native authorities to enforce compliance to bye-laws, these inspectors were answerable to the provincial health office, not to the chiefs. \(^{106}\) So, it was the province, not the chiefs that dictated issues of community public health. However, the success of those programmes depended on the support of chiefs.

The position of sanitary inspectors was problematic. While sanitation inspectors were employees of the native authority (and were paid from local treasuries), the Public Health Ordinance of 1940 stipulated that they reported directly to the provincial health office. \(^{107}\) So, sanitation inspectors found themselves at the crossroad of attending to instructions from provincial sanitary superintendents, yet adhering to local imperatives communicated by African chiefs through native councils. The problem was in the way sanitary inspectors exercised their responsibilities, and its impact on the position of chiefs during a time the chiefs were dealing with political and service delivery protests. Before 1920, public health directives came straight from the central health authority in Lagos. In most districts of south-western Nigeria, there was already a sanitary inspectorate system that started in 1910 under the Medical Officer of Health. This system, which changed with time, was

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\(^{104}\) Interview with Awoyemi Sadiat (Traditional Birth Attendant, Ojo, Ibadan), 13 July 2019.

\(^{105}\) S. 211, Criminal Code, Cap. 52, ‘Laws of Nigeria, 1948’.

\(^{106}\) NAI, IJEUPROF 1/422, vol. 4, Sanitary Inspectors General Correspondences, Ife Native Authority Bye-law, Chapter 36, 1939.

\(^{107}\) NAI, IJEUPW 1/152, vol. IV, Sanitation-General, The Public Health Ordinance, 1940.
Initially made up of mainly European sanitary inspectors. These early inspectors were mainly involved in enforcing the government policy of slum and bush clearance as an antimalarial measure; ensuring that prisons were sanitary enough, and often checked on the living conditions of a handful of Europeans in the districts.\(^{108}\)

By 1917, following the passing of the sanitary ordinance, government began training African Sanitary Inspectors and had sixty-eight such inspectors. This earlier cohort was hastily recruited from mainly uneducated Africans. They were not well trained and many of them were reported to be ‘undesirable’ elements who affected the reputation of the sanitary inspectorate. On completing their training, they served among Africans in Lagos and outlying districts.\(^{109}\) However, there was not yet any broad-based rural sanitation programme further from the city. The system changed in 1925 with the training of more African sanitary inspectors to serve in rural areas. An African Medical Officer of Health, Isaac Ladipo Oluwole, trained many such sanitation inspectors at the Yaba medical centre. By the early 1930s, the Sanitary Inspector training system had become well established with government training its inspectors at Lagos and Native Administration Sanitary Inspectors being trained at Yaba, Ibadan and Umunahia (in Owerri province) and at Kano further north.\(^{110}\) Dressed in well-tailored khaki shirts and shorts and empowered to sanction sanitation offenders, these inspectors (locally referred by the Yoruba as wole wole) were avid enforcers and symbols of colonial power. The unrestricted powers of sanitary inspectors were a cause of concern to African chiefs. Their reporting structure gave them leeway to operate in communities without reporting to chiefs. Writing to the Awujale of Ijebu-Ode (head of the Ijebu Provincial Council), his superior at the province, the Alalisan (chief) of Ilishan queried that inspectors capitalised on their support from the government to extort unsuspecting members of his community.\(^{111}\) The Orimolusi (chief) of Ijebu-Igbo also complained about the sanitary inspectors’ alleged abuse of power, arguing that it would further undermine the powers of chiefs and deprive them of their right to be consulted in all matters relating to rural Africans.\(^{112}\)

Indirect rule colonialism introduced provincial control over the activities of local authorities, thereby (in theory) limiting the powers of African chiefs. Such control was important to the colonial officials in that it was expected to guarantee local compliance to public health orders as well as ensuring that financial yields from health sanctions directly benefited the state. Obaro Ikime argued that increase in provincial and native authority staff was an attempt by the state to control local authorities on matters of taxation and the collection of fines.\(^{113}\) Since violating public health regulations had the potential to attract substantial revenues, the state saw this as an important revenue source. In practice, not all chiefs were acquiescent to the dictates of the state. Although some chiefs complied with instructions from the province, the relationship between some chiefs and

\(^{108}\)Annual Report on the Medical Department, 1910, pp. 27–33.
\(^{109}\)Nigeria, Annual Medical and Sanitary Report, 1917, p. 14.
\(^{110}\)Nigeria, Report on the Medical and Health Services for the year 1934, pp. 25–26; Nigeria, Colonial Annual Report, 1936, p. 21.
\(^{111}\)NAI IJEBUPROF 422, Vol. II, Native Administration Sanitary Inspector, Alalisan of Iiisan to the Awujale of Ijebu, Ijebu-Ode, 6 July 1934.
\(^{112}\)NAI IJEBUPROF 422, Vol. II, Orimolusi of Ijebu-Igbo to the Resident Officer, Ijebu-Ode, 2 May 1941.
\(^{113}\)Obaro Ikime, ‘The British and Native Administration Finance in Northern Nigeria’, Journal of the Historical Society of Nigeria, 1975, 7, 477.
provincial medical officers was characterised by frequent disagreements. In Ijebu Province, for instance, the sanitary superintendent issued several warnings and complaints to the *Awujale* about the failure of some of his village chiefs to comply with health regulations. He complained in 1934 about noncompliance with health rules by Chief Olugboyega of Owu district, arguing that the chief often challenged the power of sanitation inspectors in his community and also masterminded the community’s attempt to override the colonial revenue collection system. The sanitary superintendent further complained that Olugboyega instructed a family of a deceased person to bury their dead without a permit from the sanitation inspector. In Olugboyega’s response to the complaint, he challenged the excessive powers of sanitation inspectors, complaining that they were prone to ‘... occasionally netting and extorting’ villagers by imposing exorbitant fees for death certificates and sanitation fines. He prayed that chiefs be empowered to check on the excesses of sanitary inspectors. Additionally, Olugboyega questioned the reasons why African chiefs could not control health workers in their communities but had to rely on the provincial health office, arguing that this deliberate circumventing of the chief’s powers would further undermine their ability to act for the public good. The involvement of lesser chiefs like Olugboyega in public health disputes provides some insights into the ways provincial health initiatives were imagined and implemented in rural areas. By acting outside the official expectation of the provincial health office, Olugboyega was compromising the indirect rule system. This made him popular with the grassroots that expected such critique of the state’s parasitic practices.

Although the colonial state preferred Africans to patronise hospitals and dispensaries for treatment, they did not have the capacity to provide these services to the entire population. They also faced the challenge of dealing with established birth practices and the use of indigenous maternal medicines. This incapacity, together with the fact that Africans were conventional medical pluralists meant that most African authorities promoted multiple options to solve community health challenges. In his study of smallpox in Abeokuta, Oduntan found out that Nigerian colonial subjects frequently consulted multiple medical options that included western medicine, traditional healing systems, Islamic medicine and Chinese therapies, and that this complicated their relationship with the state and medical officials, especially those who did not appreciate medical pluralism. In 1934, a colonial medical officer reported that it was a widespread practice of pregnant Yoruba women to take African medicine to induce delayed labour before they were then rushed to hospitals to deliver. In some cases, the failure of western medicine gave Africans the excuse to continue using their own medicines. In 1929, the resident commissioner of Ijebu reported that some ‘recalcitrant’ chiefs such as the chief of Ilisan patronised traditional healers because the provincial health office failed to control the plague.

114 NAI, IJEBU PROF 422, Vol. II, Sanitary Superintendent to the District Officer, 30 May 1934.
115 Ibid.
116 NAI, IJEBU PROF 422, Vol. II, Olugboyega to the Awujale, 18 June 1934.
117 Ibid.
118 See Oluwatoyin Oduntan, ‘Culture and Colonial Medicine: Smallpox in Abeokuta, Western Nigeria’, *Social History of Medicine*, 2017, 30, 48–70.
119 Nigeria, Report on the Medical and Health Services for the year 1934, pp. 29–30.
ravaging the villages. During a discussion with provincial health officials in 1929, the chief argued, ‘We’ve had your medicine—it is no good, so now we’ll try ours’. 

To return to sanitary inspectors, it is clear that the sanitary inspectorate system put chiefs in a difficult position. If chiefs allowed sanitary inspectors to do as they pleased, they risked losing popularity in their areas. If they opposed and stopped these inspectors, they risked being deposed from power. A retired sanitary inspector in Ondo Province recalled some of his encounters during the early years of service in the 1940s at Ikere division. He said, ‘The Ikere chief (Ogoga) found himself in a complicated position of satisfying both the interests of his community and implementing stringent environmental policies’. He believes that these interests were usually contradictory and required the chief to choose either the people he was customarily assigned to govern or the provincial government he was coerced to serve. In the 1950s, he recounted, ‘the community attacked the Ogoga’s palace in response to some of the operations of sanitary inspectors. They protested against the closure of the community’s main market, as they thought it had been closed on the instructions of the Ogoga’. These popular unrests forced some chiefs to carefully negotiate with their subjects on how to implement some health policies in ways that did not irritate the colonial office.

In some cases, chiefs appealed to unresolved historical politics to arouse popular opposition to restrictive health regulations imposed by sanitary inspectors. The example of Olugboyega (discussed earlier) is instructive. To make this point, we briefly summarise nineteenth-century Ijebu politics and how such memories were evoked into colonial politics. Since the early nineteenth-century, Yoruba experienced episodes of political violence between Ijebu and her dependencies like the Owu and Ijebu Remo. Owu was besieged in 1817 and ultimately razed in 1822 by the Ijebu and Ife due to its relationship with the Oyo state. This was a significant blow to the Owu ethnic group, as her people dispersed in Yorubaland. With the formation of colonial administration in Ijebu in 1916, the British forcefully brought the Owu under the administration of Ijebu and Abeokuta provinces respectively. This brought discontent from the Owu who complained about their forceful amalgamation with Ijebu. Like the Owu, the Remo group saw the Ijebu hegemony as undermining their political autonomy. The Akarigbo of Sagamu (the chief of the largest Remo towns) strongly resisted Ijebu provincial administration. In 1922, Captain Buchanan-Smith, the resident commissioner of Ijebu province reported that ‘the people of Ijebu Remo had a deep-rooted and hereditary distrust of Ijebu-Ode, and the Akarigbo at intervals shows signs of intriguing with a view to the grant of a separate administration for the Remo country. I have always considered it is not an ambition that should be encouraged’. The enforcement of environmental sanitation laws merely presented an ample opportunity for the Remo and Owu to challenge the authority of the Ijebu provincial administration. Since sanitary inspectors were officials of

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120NAI, CSO 26/14556, Vol. VI, Ijebu Province Annual Report, 1929, p. 20.
121Ibid.
122Interview with Chief Bademosi (a retired sanitary inspector in Old Ondo Province, Akure, Ondo State), February 26, 2020.
123Ibid.
124Falola and Heaton, History of Nigeria, 75.
125NAI, CSO 26/14556, Vol. VI, Ijebu Province Annual Report, 1929, 13.
the provincial office, Olugboyega’s Owu saw them as enhancing Ijebu political control, which had to be resisted.

One of the many ways local authorities circumvented the sanitary inspectorate system was to discourage the frequent and prolonged visits of sanitary inspectors. Inspectors’ ‘entry ceremonies’ were hijacked by chiefs who emphasised that the community was already aware of sanitation requirements. The intention was to avoid the long, boring lectures of the sanitary inspectors and their prolonged stay in the community. Organised in very flamboyant fashion, chiefs used entry ceremonies as opportunities to negotiate the interests of the community with the sanitary inspectors. On several occasions, sanitary inspectors were dispersed within the first few days of their arrival in the villages. Moreover, community members and chiefs bribed sanitary inspectors to write favourable reports. According to Chief Bademosi, ‘... in instances when these manoeuvring failed, local authorities resorted to a more offensive approach of writing petitions to the provincial authorities’. In the 1930s, chiefs wrote many petitions to the province demanding the transfer of sanitary inspectors from their communities. Alalis an of the Ilisan native council, wrote one of such petitions in 1934 against a sanitation inspector, Mr Soeto. He argued that the inspector was exploitative and corrupt, alleging that he collected bribes from sanitary policy violators.

African Chiefs and Indigenous Healing Practices
Chiefs’ agency on matters of health and healing is also noticeable in the ways they dealt with indigenous healers. To a large extent, colonial authorities transformed acquiescent chiefs into colonial rural constable, enforcing compliance. Some of them did report traditional healers and priests who resisted smallpox vaccination. Under the anti-smallpox law of 1909, it was illegal to practice Sopona (aka Shopona) cult-worship which resisted smallpox vaccination. Sopona was a deity associated with smallpox disease. Among the Yoruba, it was believed that the Sopona deity chose whomsoever it wished to possess, afflict and at times kill of smallpox. In that regard, those who contracted smallpox were not to be mourned as the mourners and their whole family risked being stricken by the same misfortune. It was believed that anyone who contracted smallpox was a victim of the sopona, and could not get healed through western medicine. The same would however only recover if treated by a special priestess, the awuro sopona. This belief seems to have had strong precolonial roots and was largely responsible for the popular resistance to smallpox vaccination in south-western Nigeria. Reporting in 1910 on the challenges of smallpox vaccination campaigns in south-western Nigeria, the Medical Officer, Lagos said, ‘The influence of the Priesthood of the Small-pox God had its usual baneful effect—but, during the year, power to deal with those monsters was given by

126 Interview with Felix Aderibido (retired sanitary inspector, Akure, Ondo State), 26 February 2020.
127 Interview with Chief Bademosi (retired sanitary inspector, Akure, Ondo State), 25 February 2020.
128 NAI IJEBUPROF 422, Vol. II, Native Administration, Sanitary Inspector, Awujale of Ijebu to the District Officer, Ijebu-Ode, 11 July 1934.
129 O. Sapara, ‘Report to the Colonial Government on Smallpox Epidemic in Yoruba Country’, Lagos, 1 September 1909. Cited from Oduntan, ‘Culture and Colonial Medicine’, Social History of Medicine, 2017, 30, 59.
130 Elisha P. Rennie, ‘Sopona, Social Relations & the Political Economy of Colonial Smallpox Control in Ekiti, Nigeria’, in Wale Adebanwi, ed., The Political Economy of Everyday Life in Africa: Beyond the Margins (Suffolk: James Currey, 2017). 266–83.
131 Ibid., p. 266.
However, despite severe penalties against sopona adherents, and despite a hundred and thirty smallpox deaths in Ijebu alone between 1933 and 1934, Sopona worship continued unabated in Ijebu and in many other parts of south-western Nigeria in the 1930s. This resistance demonstrates the ideological contestations over disease control in African communities in the face of western medicine.

Local chiefs saw their gatekeeping positions as a means to pursue diverse political, social and economic agenda. Some chiefs used existing repressive colonial laws to control priests who were disloyal to them. Some of these chiefs wrote petitions to the government in Lagos and the police, reporting that certain healers practiced ‘quack’ medicine and consulted the Sopona deity. In 1945, Chief Lawani Fawole in Apapa, Lagos, petitioned the colonial government to investigate some sopona priests in Igbologun, a Lagos suburb, arguing that such priests were complicating government efforts to control smallpox close to Lagos. In response, the government assigned an African sanitary inspector to visit these communities and investigate the chief’s claims. He arrested some of the priests and charged them.

On the other hand, Chiefs’ attitudes towards traditional healers varied, depending on their personal relationships with those healers. The very healers that were reported by the chief of Apapa and prosecuted by the government were soon to be defended by the paramount chief, the Oba. For the Oba, it was important to protect such healers and their followers from repression because of the historical relationships between kingship and the sopona priesthood. The Oba of Lagos defended the arrested priests of Igbologun, providing cultural justifications for their non-compliance with government orders to abolish their healing practices. He averred that the symbols of worship and healing discovered by the sanitary inspector were preserved for artistic and therapeutic purposes. Furthermore, he argued that the accuser, Chief Lawani was merely trying to indict the priests because of his desire to force them to submit to his authority.

Curiously, the Oba of Lagos’ strong support to Igbologun chiefs was inconsistent with his attitude towards other healers. Just like Chief Lawani, Oba’s right-hand chief, Chief Araba assisted colonial sanitary inspectors, medical officers and the police in proscribing certain healers who, incidentally were not friends of the Oba. The Oba did not defend those healers but asked the colonial government to punish them instead. The Araba chieftaincy was established within the Oba’s palace to control the activities of healers in and around Lagos. It was customary for the Araba to report recalcitrant and non-cooperative priests to the Oba, who in turn would petition the colonial government to punish them instead. For this reason, his judgements on matters of healing were often respected and trusted by government officials, who did not realise his politics of patronage in dealing with traditional healers. By implication, local chiefs saw colonial structures as a means to sustain control over local healing practices.

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132 Annual Report on the Medical Department for the year 1910, p. 2.
133 Nigeria, Report on the Medical and Health Services for the year 1934, p. 17.
134 NAI OYOPROF 1/1728, Complaints by Late King Ologunkutere’s Descendants, Oba Falolu to the Commissioner of the Colony, 24 December, 1945.
135 Ibid.
136 Ibid.
137 Ibid.
The gain for them (chiefs) was their control on matters of healing and the financial rewards that accompanied such.

The colonial government usually consulted Yoruba chiefs for guidance on issues of traditional healing and the use of concepts in Yoruba culture. For instance, in 1948, the colonial government received a petition from the Association of Ifa Priests, Native Doctors, and Herbalists, protesting a newly registered guild’s use of the term *Ifaology* or *Ifalogist* to describe their titles. The government requested that the native authorities should intervene on the matter by explaining the concepts and decide on whether it was suitable to be used by the group. At a consultative meeting with the chiefs at the Oba’s palace in Iga Idunganran, Lagos, the commissioner of the colony heard unanimous disapproval from the chiefs against the use of the term *Ifalogist*. Among the reasons given, one Chief Oniru argued that using such a title undermined Yoruba customs and could undermine the potency of the *Ifa* deity.

Although chiefs promoted local patronage of Western medicine, their native courts also provided the space to promote African healing practices. They often gathered African healers to promote local drugs. In Lagos, the *Araba* organised medical exhibitions and provided information on the ways the *Oba* could approach healers on health-related issues. Prospective clients attended such ceremonies in the quest to ‘sample’ potential healers to consult in the future. In some areas, such exhibitions were introduced at key traditional festivals. For instance, during the Ogere festival in Isarun of Ondo State, Chief Afinmo, himself a chief priest would call on recognised healers to participate in festivities to showcase their knowledge of herbs by reciting *Ifa* verses relevant to their profession and calling. To this extent, local chiefs played a significant role in promoting African healing systems in ways that sustained medical pluralism in south-western Nigeria.

**Conclusion**

The provision of medical services in colonial south-western Nigeria between the late 1920s and 1950 required colonial authorities to take African chiefs into confidence. Chiefs were viable to colonial authorities because of the weaknesses of state institutions and medical missions to penetrate rural communities with medical services. This approach was economical as it afforded colonial government to use administrative authorities that had entrenched position on health and healing. By allocating chiefs the power to promote rural medical services and to enforce medical-related policies and by-laws, colonial authorities in Yorubaland were not guaranteed to yield the desired result. This is because in executing their duties, chiefs exercised their agency and discretion on how to implement received policies. In the face of looming legitimacy crisis, chiefs tried as much as possible to consult with their subjects so as to retain relevance. They also used laws to

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138 NAI OYOPROF 1/1728, The Union of Nigeria Herbalist and Ifalogist, T. Balogun to the Registrar of Companies, 10 November 1948.
139 NAI OYOPROF 1/1728, The Union of Nigeria Herbalist and Ifalogist, Minutes of Chiefs’ Monthly Meeting held at Iga Idunganran, 25 January 1949.
140 OYOPROF 1/1728, ‘Complaints by Late King Oloqunkutere’s Descendants’, Oba Falolu to the Commissioner of the Colony, December 24, 1945.
141 Interview with Alhaji Fatai Owoseni, (herbalist, Ipaja, Lagos), 24 July 2018.
142 Interview with Oba Adebobola Josiah, (the Asarun of Isarunland, Ondo State, Nigeria), 15 July 2018.
entrench patronages and loyalty, particularly by punishing priests and indigenous medical services providers into submission, and by defending those who were already loyal to them. Herein lay the corrupting nature of power accorded them under indirect rule colonialism.

In some instances, where chiefs felt undermined by sanitary inspectors, they tried to delegitimise such inspectors by accusing them of corruption and of being harsh on their subjects. In other instances, chiefs deliberately aligned with their people in agitating for infrastructural development and overall health service delivery. In this way, they demonstrated adaptability to emergent popular political interests, especially in the 1940s when African nationalism was on the rise in Nigeria. Chiefs also used their courts to promote indigenous medicine-men who demonstrated their medical knowledge to their community members, thereby promoting medical pluralism. The role of chiefs in rural medicine remained obscure in that on one hand, they were supposedly empowered to enforce compliance as well as to fund rural health, yet on the other, they found themselves having to battle with the sanitary inspectors for the control of rural health.