

# **Colonialism and Diseases Control in Idoma Division, 1938-1960**

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## **Abstract**

The presence of the British colonialists in Idoma Division predates 1938. However, prior to and within the period of this study, the British colonialists began to take giant steps in the enactment of health policies that would create the enabling environment for the realization of their colonial interests, such policies include: the Sleeping Sickness Ordinance of 1936, the establishment of Native Administration Dispensaries Policy and Instructions, the creation of Western Districts Leper Segregation Area, Oglewu District, 1951, Eggede Leper segregation area, 1949, The Public Health Ordinance of 1950, Vaccination Ordinance, chapter 53 of 1945 and the Native Administration Dispensaries Policy and Instructions, 1939-56 among others. Despite the health policies enacted by the British colonialists, much or virtually nothing had been written on the aspects of health in Idoma Division, which is a major historical lacuna. Available literatures tend to concentrate on the socio-economic, political and cultural lives of the people, hence, this study is poised towards bridging this historical lacuna in the study of the history of the people of the Division and also to deepen our understanding on colonial health policies in the division. In order to reconstruct this vital aspect of the people's history, the paper employs historical methodology in the process. This includes the collection and the interpretation of primary data from the archives as well as conduct of oral interviews and the collection of secondary sources.

## **Introduction**

One of the greatest historical phenomena that had shaped the history of Africa, Nigeria and Idoma Division in particular, was colonialism. Colonialism which has to do with the conquest, subjugation and domination of a people by another had left an indelible mark on the history of the people of Idoma Division. The conquest and domination of the people by the British colonialists brought about changes in their socio-economic and political lives which would not have been possible without the health policy enacted by the colonialists. Health affects every aspects of man's life-social, political, cultural and economic, the absence of which will definitely impact on every sphere of his life.

Much has been written on colonial conquest, domination, socio-economic, political and cultural lives of the people of Idoma Division, but to the best of our knowledge, virtually nothing or little had been written on the health aspect of the people. The primacy of health in determining other aspects of man's life cannot be overemphasized; without good health there can be no socio-economic and political developments. Hence, this study is poised towards examining the preventive and the curative measures the British colonialists took towards the control of prevalent diseases present in Idoma Division, especially from the period 1938 to 1960 and how they impacted on the socio-economic and political lives of the people. This will help to bridge the historical lacuna created in the omission of this aspect of the people's history and also deepen our understanding on colonial health activities in the division.

Attempts had been made by several scholars and health organisations to define health: The World Health Organisation (WHO) defines health as a state of complete physical, social and mental wellbeing and not merely the absence of disease or infirmity. This definition of health by WHO was at its conference at Alma Ata in the Soviet Union in the 1978.<sup>1</sup> Bannerman opined: "traditional society regards health as a state of balance or equilibrium, both internal and external, this equilibrium is based on variations of humoral substances and forces involving balance of opposing qualities"<sup>2</sup>

### **Location and Scope**

Idoma Division was a colonial creation in 1928, located in the Southern valley of the Benue River. On the West the Division had boundary with Igala Division, on the East with Tiv Division and on the South-East with Ogoja province in Eastern Nigeria. It is about 144kms from the North to the South, and about 32kms from East to West.<sup>3</sup> It lies within latitude 6° 30' North and longitude 8° East.<sup>4</sup> The Division comprises several linguistic groups such as Idoma, Igede, Akweya and Ufia, this implying that the name Idoma does not apply to all the groups in the Division because, only few traced their origin to the Idoma's Founding father Idum or Idom. However, for the British administrative convenience, all those found in the Division before the coming of the British colonialists were regarded as Idoma after the conquest of the area.<sup>5</sup>

The journey that finally culminated in the creation of the Division started as far back as 1899 or earlier when the British colonialists made their presence in the Division, engaging the people in one trading relations or the other. By 1908, the Division witnessed dramatic change when one Colonel Trenchard carried out a military expedition during the Niger-cross expedition. He succeeded in penetrating the Southern and the Eastern parts of Idomaland. From that point, several unprecedented expeditions such as Ukelle Escort of 1922 and Ogbuloko rebellion of 1928 were carried out.<sup>6</sup>

The geography of the area was among the basic factors that attracted the British colonialists to the area. It is generally endowed with mineral resources, such as bauxite, common salt, lime stone, gypsum, coal, clay and stones.<sup>7</sup> The coal and lime found in the present day Ogbadibo and Ado Local Government areas were

mined during and after colonialism. The Division lies within the oil palm belt though it abounds more in the South and West than in the North and East. Some of the important exports from the Division are palm produce, oil and kernel. Other economic trees found in the Division include *Iroko*, *Mahogany*, *Obache*, *Silk-cotton* and *rubber* trees, mainly found in the forest area. The trees were of high economic value to the British during the colonial period.<sup>8</sup>

### **Curative and Preventive Measures in the Control of Prevalent Diseases in Idoma Division**

Several curative and preventive measures were taken by the British colonialists in the control of prevalent diseases in Idoma Division especially from the period 1938 which marked the beginning of this study. This became absolutely necessary, if there must be a conducive environment to facilitate the achievements of the British Colonial goals. Secondly, as it is popularly said "health is wealth", without good health, the efforts towards achieving British Colonial interest will result in futility, hence, the need for them to safeguard their health.

Small pox was a disease which threatened the lives of several people before and during the colonial period. Before the colonial conquest and domination of the Division, superstitious beliefs developed around the disease. It was believed that the provocation of the gods or their ancestors was largely responsible for the ailment. During the colonial period the sickness assumed a new dimension as a result of the pattern of settlement and overcrowding, especially in the urban areas and British labour camps.

Several sicknesses spread faster during the colonial period compared to the pre-colonial period. The bringing together of people from different backgrounds facilitated the spread of sexually transmitted diseases. During the colonial period, there was frequent visits of traders from both far and near, labourers conscripted into colonial labour camps from different Divisions. This type of interrelations and contact brought about the easy spread of diseases that were alien to Idoma Division.

At a point in time, the divisional officer in Idoma Division wrote to the Resident, Benue Province in Makurdi on the 18<sup>th</sup> December, 1932 informing him on the report from *Obokolo* village area, *Okwoga* district on the outbreak of small pox. Though the statistics on the numbers of affected persons was lacking as a result of dearth of materials, evidence shows that good number of persons were affected which prompted the British colonialists to embark on vaccinating the people to prevent the continual spread of the disease. Considering the urgency of the exercise, the divisional officer informed the medical officer on the 13<sup>th</sup> December, 1932 explaining the nature of the exercise. He requested two Idoma Native Administrators dispensary attendants undergoing a course of training in Makurdi to be released to help in the exercise.<sup>9</sup>

Among the short comings of the exercise was inadequate vaccinators to carry out the exercise, inadequate supply of lymph and other equipment needed to carry out the exercise. The British colonialists were not willing to train good numbers of locals in the health sector. This was largely informed by the prejudice or misconception they had concerning the people of the Division as primitive, barbaric

and incapable of any meaningful development. High level of discrimination was exhibited against the people, their salaries was nothing compared to British colonialists occupying the same position with an indigene of the Division in terms of position.<sup>10</sup>

Attempt by the British colonialists to build dispensaries in some parts of the Division also raised some serious issues of concern. The dispensaries were poorly equipped, such that most of them never met the standard of a dispensary. On the issue of staffing, it was very poor because it lacked enough staff to carry out its day-to-day activities. All these were tied to the fact that the British colonialists were not ready to spend on health more than what they had budgeted. Releasing extra funds means over expenditure and it was based on these inherent weaknesses that the Divisional officer wrote to the resident of Benue Province that:

What we require is an adequate number of locals trained as vaccinators and an adequate supply of lymph. There are two vaccinators in the Division at present and with the two dispensary attendants and a supply of 120 tubes of lymph per month. We should be able to get the people vaccinated at the rate of over 1000 per month.<sup>11</sup>

This statement revealed the shortcomings inherent in the colonial health policy in Idoma Division, it is evident that as a result of the lack of attendants, lack of medical equipment, like lymph among others, the British colonialists had to utilise what they had. The exercise was carried out not because of meeting the pressing needs at hand, but according to the resources in human and material forms at their disposal.

Sleeping sickness was another disease the British colonialists contended with as early as 1904. Hundreds of people died and many others invigorated from one place to another as a result of the disease.<sup>12</sup> By 1929, Sleeping sickness officers toured the Districts, diagnosed and treated some cases. They spent little time in some villages and gave few injections before returning. In the Division, there were cases of 3,629 persons infected with the Disease but only few persons were treated out of the total number.<sup>13</sup>

Considering the inadequate time given by the sleeping sickness officer in 1930, they were instructed to spend quality time in each locality. A survey was carried out in July and August by two sub-teams under Dr. Hollins in charge of the Northern and Western touring area and another under Mr. Sidebotham, who was in charge of South-Eastern touring areas. Tables one and two showed the results of cases identified in the North Western and Southern-Eastern tours.<sup>14</sup>

Town	No. Seen	Gland	Positive	Percentage
Bagaji	398	77	14	3.5
Oguja	93	25	5	5.4
Ochibudu	101	26	4	4.0
Ojanue Ile	133	30	-	-
Bopo	177	40	2	1.1
Ijoke	150	20	-	-
Aijeti	187	54	-	-
Awuke	166	34	-	-
Igga	194	28	-	-
Adoka	511	56	9	1.3
Boju	251	31	-	-
Atakpa	128	15	-	-
Ogenne	211	21	-	-
Ijame	276	33	-	-
Ochobu	353	14	-	-
Ikeh	101	16	-	-
Ogbokoto	601	25	-	-
Obu	424	24	1	.24
Otukpa	870	44	2	.23
Orokam	754	36	-	-
Owukpa	1297	44	1	.07
Ibokobonu	134	6	-	-
Okwoga	146	9	-	-
Ogbujigu	355	17	-	-

**Source: Makprof /1106D/ Report on sleeping sickness 'SPOT' survey of Idoma Division, Benue Province, 8th September, 1940**

Table one further reveal that out of the total number of persons surveyed, it was only few persons that had the disease. In the case of *Owukpa* which had the highest number of persons surveyed, it was only fourty four (44) that were found with the sickness. A critical evaluation of the table shows that the British were either getting control over the spread of the disease or failed in carrying out extensive work of survey in the districts to identify much cases.

A critical evaluation of the result collated by the South Eastern Touring Team in the course of the survey also revealed a similar problem with the previous result. Table two below reveals the number of those examined in the towns, as well as those affected and the percentages in general .

Town	No. Seen	Gland	Positive	Percentage
Otobi	423	34	-	-
Utonkon	898	51	3	3
Nyelele	138	7	-	-
Igumale	468	44	16	3.4
Agara	837	67	4	.4
Avagba	257	16	1	.3
Ikache	116	8	-	-
Oju	147	10	-	-
Andibila	123	9	-	-
Ojaba	66	3	-	-
Adoga				
Ombi Oruru	38	4	-	-
Ameka	17	2	-	-
Anchimagba	31	3	-	-
Abutu	151	20	4	.2
Aloma	80	8	2	2.5
Ijigbiam	646	54	6	.9
Edam	254	27	2	.7
Otukpo	782	71	15	1.9
Asa	150	32	-	-
Prison	144	31	1	.6

**Source: Makprof/1106D/ Report on sleeping sickness 'SPOT' survey of Idoma Division, Benue Province, 8th September, 1940.**

Just like the North West survey report, this report also shows the numbers of persons examined by the survey team, as well as the percentages affected by sleeping sickness in the area. Comparing the two results of the reports, one can find

the deficiencies inherent in the north-west tour are not far from that of the south-east tour because an extensive survey was not carried out. The simple reason was that the British colonialists were not ready to spend much money on training the people of the Division as doing that would be waste of resources. More so, because of the prejudice the people had against the British colonialists, good numbers of them did not submit themselves for the exercise.

As efforts progressed towards the control of sleeping sickness in the Division, Vaccination Ordinance was put in place. In the exercise of the power conferred upon the Native Authority, the *Otukpo* Native Authority Ordinance of 1945 was approved by the Resident, Benue Province on the 4<sup>th</sup> June, 1945.<sup>15</sup> Section 10A of the vaccination ordinance conferred some powers on the Native Authority and it was based on this fact that the Native Authority operating within the context of the power that stated “all adults and children who cannot produce satisfactory result of a successful vaccination, or having been attacked by small pox or other diseases prevalent in the Division should be vaccinated as directed by the Native Authority, or any authorized person.”<sup>16</sup>

Another inherent problem responsible for the ineffectiveness of the colonial health management was the attitude of the indigenous people. One must try to balance this argument because, in as much as the British colonialists were clouded by their colonial interest of exploitation and seems not to give adequate attention to the health needs of the people from the onset, the manner in which the people also responded to the efforts made by the British colonialists was discouraging, that was why rules concerning vaccination in the Division were reinforced under the Native Authority.

Such re-enforcement became necessary as a result of the way people absconded from being vaccinated. Without compelling the people, when such declaration for a vaccination exercise was made, majority of the people keep on absconding. It was based on this fact that the rule was re-enforced under the Native Authority so that anyone found wanting in keeping to it was severely punished. The exercise of this rule was not only restricted to the natives of the town, but as well as settlers from other provinces or divisions, who were expected to comply with the same rule and expected to make themselves available for the vaccination exercise.<sup>17</sup>

Major strides continued to be taken by the British colonialists in order to avoid the spread of sleeping sickness because, the sickness continued to spread especially in Northern parts of Nigeria. This necessitated a memorandum from the Secretary of the Northern provinces to the Resident, Benue Province asking him to comment on the sleeping sickness ordinance draft enclosed in the memorandum. This was because, the British colonialists had seen the need to institute a sleeping sickness ordinance to make provision for the prevention of the spread of sleeping sickness and the compulsory treatment of those persons infected.<sup>18</sup> This ordinance was applicable to the entire Northern provinces which the area was part of.

With the provision of the sleeping sickness ordinance of 1936, drastic measures were taken by the British colonialists to prevent the spread of sleeping sickness in Idoma Division. There was a compulsory examination of persons infected or suspected to be infected with sleeping sickness. The examining officer may require

any person he suspects of being infected with sleeping sickness to submit for medical examination at the place stipulated and failure to comply means guilty of an offence. Treatment was usually compulsory for those who presented themselves for medical examination and found to be affected.<sup>19</sup>

Some areas were declared sleeping sickness as a result of the prevalent situation of the sickness. This was done when the disease was found or was likely to break out in any part of the Northern provinces. The governor may be ordered in a council to define such places and declare it sleeping sickness areas. In some cases, people were asked to evacuate depending on the extent of the infection. The examining officer had the right to enter there and inspect the place.

Rights were given to any Resident in charge of a province or any Native Authority within the area of his jurisdiction for the purpose of arresting or preventing the outbreak or spread of sleeping sickness. In any sleeping sickness area, they were authorized to direct the making and maintenance of protective clearing, prohibit persons from residing in, assembling at, resorting to, or frequenting particular places and prohibiting persons from journeying along any specified road, or along any other than a specified road and directing persons, residents within or visiting the area to move either temporarily or permanently outside the area, or from any other place to another place within the area.<sup>20</sup>

Some places considered to be infected with the disease were usually declared as restricted areas to prevent persons from contacting the disease and once a place was declared a restricted area, any person who enters such place without a permit issued to him by a District Officer, or by a Native Authority authorizing such entry, that person was guilty of an offence. If a person intends to enter a restricted area, he shall present himself one month before that time to the examining officer for examination. Until the examining officer was convinced on why the person be granted permit, the District Officer or the Native Authority cannot issue permit to the person.

However, government and Native Administration Officials on duty were exempted from the regulations stipulated in the ordinance because they and their agents were granted free entry to the restricted areas. Besides, they had the right to restrict the entry of cattle into or movements of cattle within a sleeping sickness area. Let us bear in mind that the institution of sleeping sickness ordinance in Northern Nigeria which the area of study belongs to was a major step taken by the British colonialists towards the control of the spread of sleeping sickness.

Steps were taken by the British colonialists to tackle the challenges of leprosy in the Division. As far back as 1874, the Mission for Lepers was founded which later became The Christian Leprosy Mission. However, in 1923, the British Empire Leprosy Relief Association (BELRA) was founded which marked another phase of development towards the control of the disease.<sup>21</sup> The establishment of this organization brought about the opening of leper clinics in the Division. In Igede, a leper clinic was established in 1952, having about 420 lepers undergoing treatment. The breakdown is as follow: Egede- 222, Ito- 125, Idoma- 60, Izzi- 13, bringing the total number to about 420 at Egede settlement.<sup>22</sup>

The communication of the knowledge of personal hygiene and sanitation were highly upheld by the British colonialists through the sanitary inspectors. Hygiene was taught in schools and it became a very important part of school curricular. At the domestic level, the house wife was the target; when she is taught, it was believed the message will be disseminated to other members of the family. The British colonialists believed that lack of knowledge of personal hygiene and cleanliness were largely responsible for the transmission of diseases such as Tuberculosis, Leprosy, Small pox, Guinea worm, Blindness, Ulcer among others. Therefore, sanitary inspectors were asked to explain to people the simple health tips and why they should be followed.

Furthermore, the people were encouraged to wash their bodies daily, wear clean cloth, put their beddings in the sun from time-to-time and wash their hands before eating. To cap it all, they came out with a slogan “Where there is darkness there is dirt, where there is dirt there is disease and where there is disease there is death.”<sup>23</sup>

As efforts towards the control of diseases in the Division continued, alternative source of water known as colonial wells were built. They were built mainly in places that lacked streams or rivers that could sustain the people throughout the year. Colonial wells were built in places like *Otukpa*, *Orokam* and *Igumale*. Relics of some of the wells are still traceable in the Division.<sup>24</sup>

In spite of the efforts made by the British colonialists towards the control of prevalent diseases in the area, much still need to be done. Good or bad health conditions are determined by multiplicity of factors: environmental conditions, genetic factor, income, educational level and even the very relationship with families and friends are all factors that could determine man’s good or bad health condition. Based on these preconditions, the need to consider the reason why colonial efforts towards the control of prevalent diseases did not actually yield the expected result.

Socio-economic and political factors are necessary determinants of good health. Under colonialism, taxation brought great financial and economic burden and hardship upon the people. Taxes during the period were regular and inflexible in order to meet the budgeting procedures of the fiscal year. No consideration was given to harvest failure, local calamity or individual calamity; rural producers were expected to pay a minimum of thirty percent (30%) of their net profit. To worsen the matter, the Native Authorities were over assessing the people as well as extorting them. These factors led to the migration of people from one locality to another and hence, caused the spread of diseases.

Colonial policy of forced labour was such that court messengers known as *Idengeli* in the local dialect were sent to conscript people into the forced labour, it was usually a bitter experience for the people especially those the messenger had much trouble before being caught. They were treated with brutality, chained and led to the scene of the work. They were denied and deprived of the warmth of life. Their place of abode during the period of labour which might last from six to twelve months was nothing to write home about. They were kept in a slum that lacked ventilation and continued to have contact with people from different provinces encouraging the spread of diseases.<sup>25</sup>



The policy of discrimination against the people affected the effectiveness of the health policy, the British colonialists settled at the best places known as “European Reservation Area” where farming was strictly prohibited. It was also believed that farming and high grasses could be responsible for the spread of diseases. Dustbins and latrine pails were only given to government European bungalows, boys quarters government offices, government schools, clerk’s quarters and government rest house. Public latrines in township, Native Administrations offices, dispensaries, schools, market areas and prisons were neglected.<sup>26</sup>

### Conclusion

In conclusion, this paper examined colonialism and disease control in Idoma Division from 1938-1960. It identified the various health policies enacted by the British colonialists in the control of diseases in the area. It was argued that it became incumbent for the British colonialists to enact health policies that would safeguard their health if the British economic interest of exploitation must be achieved. Hence, they enacted different health policies to control sicknesses such as small pox, sleeping sickness, leprosy, malaria among others. However, these steps were welcomed with resentments by the people of the Division as a result of the nature of the British conquest and domination of the people.

The paper argued that the interplay of several factors such as social, political and economic are determinants of good or bad health conditions, hence, the British colonial social and economic policies contributed in the spread of diseases in the Division. The people’s disposition towards the British colonialists was also among the factors that affected the health policy enacted by the British colonialists. On the whole, economic interest much more than any other reason informed the steps taken by the British colonialists in Idoma Division in controlling the prevalent health issues and this also explained why after colonialism the health policies were not sustained for the continual good and benefits of the people.

### Footnotes

1. WHO: World Health Forum, An International Journal Of Health; Geneva, Vol.2 No.1, 1981,P.21. Also see World Health Organisation Country Health System fact Sheet, Nigeria, 2005.
2. R.H., Bannerman; “The Traditional Medicine in Modern Health Care “ in WHO: World Health Forum: An international Journal of Health Development, Vol.3; No.1, 1982, p.2.
3. Ode, G., “The Impact of British Colonialism on the People of Idoma Division, 1908-1950”, M.A Thesis, Dept. of History, Ahmadu Bello University, Zaria,p.1
4. Udoh, R.K,*Geographical Regions of Nigeria*, Heinemann, London, 1970, Pp.138-140.
5. Ode, G., “The Impact of British Colonialism on the People of Idoma Division, 1908-1950”, M.A Thesis, Dept. of History, Ahmadu Bello University, Zaria, p.1

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7. The Idoma National Forum, Request to create Apa State out of the present Benue state. A memo presented to the national constitutional conference, 30th July, 1994. Also, the Apa State Movement: The Economic Blue print of the proposed Apa State; a memo submitted to the Committee for the Creation of State, Local government and Boundary Adjustment, Makurdi, 26hMarch, 1996.
8. Ode G.E., "The Impact of British Colonialism on the People of Idoma Division, 1908-1950", M.A Thesis, Dept. of History, Ahmadu Bello University, Zaria, p.1-2, p.5. for details check R.K Udoh, *Geographical Regions of Nigeria*, pp.138-147.
9. Makprof/811/Public Health Rules/NAK.
10. R.Schram, A History of the Nigerian Health Services, Ibadan University Press, Ibadan, 1971, p.130.
11. Makprof/812/Public Health Rules/NAK.
12. A.J. Duggan "Sleeping Sickness Endemic" in E.E. Sabben Clare et. Al, *Health in Tropical Africa During the Colonial Period*, London, 1980, P.24.
13. Makprof/1106AD/Report on Sleeping Sickness "Spot" Survey of Idoma Division, Benue Province/NAK.
14. Makprof/1106AD/Report on Sleeping Sickness "Spot" Survey of Idoma Division, Benue Province/NAK.
15. Makprof/479/Vaccination Ordinance, 1945, NAK 16 *Ibid*.
17. Oral Interview with Mr. Abel Idu, a palm wine tapper resident at Igumale on 13/5/2013, age, 53 years.
18. Makprof/1106A/Memorandum for Sleeping Sickness Ordinance, 1936.
19. *Ibid*
20. Oral Interview with Mr. Abel Idu, a palm wine tapper resident at Igumale on 13/5/2013, age, 53 years
21. R.Schram, op.cit., p.230.
22. MaRKPROF/1938/S.4/Egedde Leper Segregation Area/NAK.
23. Makprof/1876/Medical and Health Campaigns/NAK.  
24 Edache Ochekwu, a farmer residing at Adoka, 8/6/2013, Age:64 years.
25. Mr. Odihi Adikwu, a palm wine tapper in Ogbokolo, 5/5/2013, Age:73 years.
26. Makprof/2176/Sanitation General Notes and Correspondence/NAK.

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**Makprof Collection (Vols. I and II)**

- 382/8.3 Lists of dispensaries in Idoma Division, 1950
- 2176/ Sanitation general notes and correspondence
- 1106D Report on sleeping sickness "Spot" survey of Idoma Division, BenueProvince, 1940
- 1106H Sleeping sickness report, Idoma Division
- 1015 Memorandum from the secretary, Northern provinces to the Resident Benue Province, 1940.
- 1938/5.6 Western Districts leper segregation Area, Oglewu District, Idoma 1951
- 1938/5.4 ggede Leper segregation area, 1949
- 1015 Leprosy Relief Abinsi Division, 1931
- 811 The Public health Ordinance, Chapter 183, 1950
- 479 Vaccination Ordinance, chapter 53, 1945.

- 382C Utonkon Dispensary, 1948  
 1876 Medical and Health Campaigns, 1936  
 213/3775 Native Administration Policy 1933-34  
 382 Native Administration Dispensaries Policy and Instructions, 1939-56.  
 267/1 Handing Over Notes: Idoma Division 1933-48.  
 550B Otukpo District (Idoma Division) Intelligence Report on, by Captain G.D.C. Money, D.O.

### Oral Interviews

- Hon. Michael Ubah Obande who is a registered committed health practitioner is one of our informants who gave us useful information on health issues before and during the colonial period. He is resident at G.R.A. *Otukpo* and about 72 years. Oral interview was conducted with him on 4/16/2013 at his residence, he worked with the health center at *Otukpo* after the colonial period.
- Mr. Edwin Obla is a retired civil servant that worked in the early sixties with the civil service. According to him, he had worked with some of the white men immediately after the independence which was the period he was employed into the civil service. We interviewed him on 5/4/2013 at his residence in *Ugboju*. As of the time of the interview, he discloses to us that he is a pensioner and at the same time into farming. He is about 63 years of age.
- Adikwu Ogbu: he is a farmer who is based in *Utonkon* district of Idoma division, he is about 55 years. This interview was conducted on 6/5/2013 at his residence in Utonkon.
- Agadagba Joseph was another informant who gave us useful information on this study, he is about 71 years. This interview was conducted on 8/4/2013 at the market square, we booked appointment with him and he took us to the market square and asked us to be free to discuss with him.
- Adakole Abah who resided in *Otukpo* town but a native of *Edumoga* in the division did not only give us useful information, but also linked us with those whom he considered knowledgeable on our theses. Through him, we got information largely on the early people who worked with the colonialists in Idoma division. He discloses his age to be 73. The interview with him was conducted on 14/3/2013. Adakole Abah obtained his secondary school certificate in Adoka, he worked with the civil service and retired about twelve years ago, he gave us useful information that was relevant to the study.
- Audu Ogbole a retired civil servant who worked with the health center at *Adoka* in the division, but presently owning a Pharmacy gave us useful information on the research topic. He is about 67 years; he resides in *Adoka*. The interview was conducted on 14/4/2013 at his Pharmacy and on the following day we went back for more information.

The information from Mr. Ochefu Adah residing at Okpoga was instrumental in enhancing our knowledge on the pre-colonial activities of the people of the division. Through our interview with him on 15/3/2013, he discloses much information on the nature and implementation of the health policy enacted by the colonialists in Idoma division.

Ogbole Ominyi is a former medical practitioner who is about 76 years. He disclosed to us that he worked with few colonialists towards the end of the colonial era and from experience was also able to give us useful information on the nature of colonial health policy in Idoma division.

Ogboji Ashadu a man of 73 years though, look much younger than his age whom we had interview with by appointment at late evening hours in his residence on 24/4/2013 told us much on certain belief systems on the causes of ailment and as well as how people were treated most especially those having leprosy and small pox which are among the diseases the people look at as having supernatural cause.

Mr. Ode Agbaji was also interviewed on 25/4/2013 in his residence, he is about 61 years, much of the information he gave to us were on the traditions of the Idoma people, what is accepted as norm and what is not accepted as well as offences considered as taboo.