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Research Article

Multilateralism in Medical Care in Colonial West Africa: The Okun-Yoruba People 1884-1915

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Abstract

The synthesis of multilateralism in medical care among the Okun-Yoruba people was contemporaneous with the emergence of colonisation. The study examine the religio-cultural belief system of disease causation and treatment modified in the concept of ethical monotheism in Okun-Yoruba tradition. It explores the evolving practice of multilateralism in medical care among the OkunYoruba people of colonial West Africa from 1884-1915. Offering a sharp contrast in the interplay between traditional Yoruba healing practices and Western Medicine introduced by the British colonial government and missionary societies. Despite the divergences in medical care and the unceasing colonial efforts to suppress traditional medicine, a broad coexistence and adaptation in the idea of medical care was forged. On the whole, the Okun-Yoruba people and their communities navigated multiple medical systems, incorporating the idea of Western Medical care while preserving the knowledge of traditional medical care. This study highlights the Okun-Yoruba medical traditions and their continued relevance in the wake of colonial pressures.

Keywords

Multilateralism, Medical Care, Colonial West Africa, Okun-Yoruba People.

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Introduction

Colonization had made a competition of ideas in medical care possible among Okun-Yoruba people by exposing them to colonial forces, missionary societies and their philosophies. Having surrendered their internal socio-political autonomy and territories to the protection of the British colonial powers. They had to battle with the clash of idea in the concept of medical care. The Okun-Yoruba people were confronted by the clash of civilization between their Traditional medical care practice and Western biomedicine imposed by British colonizers. This led to multilateralism in medical care and tensions between preserving religio-cultural belief that shapes the traditional concept of disease causation, treatment, and adapting to new healthcare ideas. Under the influence of British colonisation, traditional healers, colonial authorities, and missionary societies had to navigate multiple medical paradigms, influencing healthcare outcomes and shaping the regions medical heritage that has stood through generations.

How was the Europeans able to phantom the idea of colonisation which led to the imposition of her medical idea on the Okun-Yoruba people. By 1884-1885, the desire to colonise Africa reached its peak with the convening of the Berlin conference. These growing European interest in Africa coincided with the Royal Niger Company driving out her French competitors in 1884 and

expanding her territories of activities over the Sokoto Sultanate [1]. Meanwhile, Britain already gained theoretical control over large territories in West Africa at the Berlin conference. But the region was devoid of formal mapping, even the continent of Africa as a whole [2]. These untidiness that generally characterized boundary delineation slowed the machinery of British colonial rule and became a disappointment at the boundary demarcation of the boundary between the Royal Niger Company, the Lagos colony, and Oil Rivers protectorate in 1894 [3]. Regardless, attempts to transfer on the ground a vague boundary description to establish the legacy of British colonial administration began. The first boundary commission was established in 1894 with Captain Robert Lister Bower as a representative of the Lagos government and Fredrick Lugard representing the Royal Niger Company and the Emir of Ilorin [4]. A rough demarcation was carried out to clear the doubts on the southern limits of the power of the Emir of Ilorin with little or no consideration given to ethnological and other factors. However, the dream at the conference of Berlin for a British colonial administration in West Africa was gradually unfolding into reality. By 1899 several northern states had come under trade protection of the Royal Niger Company authority with a lot of practical consequences that followed [1]. By 1900 British colonial government took over the whole of these territories from the Royal Niger Company and established the protectorate of Northern Nigeria [1]. Finally British imperial government arose and imposed her authority as a powerful force. The territories were all conquered with British indirect rule installed on them, which symbolized the formal establishment of colonial rule. In this determination of colonial rule Fredrick Lugard structured a three level system of government, the district, division and provinces under the British colonial rule. The Okun-Yoruba people under this arrangement became grouped under Kabba Province of the Northern Protectorate of British colonial West Africa.

In many instances, the act of colonization was justified by Europeans for its success in the spread of western education, superiority in western science, development of a unified global health system and its civilizing mission ideology amongst the Okun-Yoruba people. However, it had its drawbacks, amongst which was the clash in civilization in the idea of disease causation and treatment between traditional medical care and western medicine. Mary Kingsley a British ethnographer who worked in West Africa, influenced European views on Africa through her published work titled, "Travels in West Africa", her work highlights indigenous Africans medicinal practices were often misunderstood by Europeans and advocated for respecting African knowledge [5]. Early interface between traditional medicine and western medicine under British colonial rule characterized by scientific racism, on European culture of medical care was viewed as primitive. This mindset led to the unjust condemnation of the Okun-Yoruba idea of traditional medical care.

Conceptual Framework

Multilateralism in Medical Care

Multilateralism in Medical Care refers to a concept of multiple healthcare approaches in disease diagnosis and treatment. In the contest of these research it highlights the interface between traditional medical with western medical care and reactions from both the Okun-Yoruba people and the colonialist. The Okun-Yoruba people had a healthcare system interwoven in her religio-cultural belief which relied on ethical monotheism, effective herbal remedies for disease prevention, and treatment built upon group theraphy methods within the family, lineage and community. The had no western scientific medical knowledge of germ theory, and multiple gestation. Women with multiple pregnancy delivered of twins were seen as less humans which made infanticide practices common among some communities [6]. However, this perception of the Okun-Yoruba led to clash in civilization in the idea of medical care with the interface with western medical care. Superior powers of British colonial rule subjected the practice of traditional medicine under colonial authority, outlawed practices that they felt should be outlawed and that which could interplay with western medical care remained. This began multilateralism in medical care among the Okun-Yoruba people with the thorough supervisory role of British colonial residents and districts officials and missionary societies that often provided reports on cultural practices and events of the people in their various mission stations.

Okun-Yoruba People

The Okun-Yoruba people are a sub-Yoruba group. Early efforts by historians to provide a common account for the origins of the Yoruba speaking group that occupy two distinct geographical locations with more than ninety percent in Southwest and less than ten percent [7] in Kwara and Kogi of Northern Nigeria was purely legendary. Samuel Johnson attributes the obscurity in the origin of the Yoruba's to the people being unlettered and the language unwritten, all that was known was from traditions carefully handed down [8]. Prior to colonisation several cultural states were associated to the Yoruba people, among which are, the Ekiti, the Ijebu, the Ijesha, the Okun, the Oyo, and lots more. It was only in colonisation when arbitrary boundaries was created under the first boundary commission of Captain Lister Bower and Fredrick Lugard [4] that a rough demarcation was done bringing close to ten percent of the Yoruba's under the Northern Protectorate of British colonial Nigeria [4]. This created the designation sub-Yoruba group. The ethnology of these cultural groups was not put into consideration during these boundary creation. Okun people an associated cultural state of the Yoruba before colonisation became classified under Kabba Province of Northern Protectorate under the British colonial rule in 1901. Hence the categorization of the Okun people as a sub-Yoruba group because of their new representation under the Northern Protectorate of British colonial arbitrary boundary demarcation and mapping. Undermining the common religio-cultural belief in the concept of ethical monotheism as an ethnological factor among all Yoruba speaking group which the Okun tradition was a big integral. These distinctions and complexity had significant effect both on the political representation and the interplay between traditional and western medical care. Based on this new characterization of a sub-Yoruba group under colonial arbitrary boundary creation

and mapping. The Okun-Yoruba people became comprised of five distinct sub-groups, namely Bunu, Ijumu, Iyagba, Owe, and Oworo in the Protectorate of Northern British colonial Nigeria [9]. These associated Yoruba cultural state adopted a single identity called Okun taken from her general mode of salutation or greetings as her new mode of identification under British colonial rule.

Colonial West Africa

In view of the fact that imperial Britain exerted much influence on the tropical waters of West Africa through the territories of Free Town in Sierra Leone, Gold Coast Ghana, Lagos, Calabar, and Lokoja in the Niger, made this areas to be referred to as Britains West African colonies. The term "West Africa" was a designate for the geographical grouping of specific territories in West Africa under British colonial administration. British socio-economic, and political policies under colonisation within this territories were managed together under West Africa for administerative convenience [10].

On this basis, exploring multilateralism in medical care among the Okun-Yoruba people in West Africa involves the understanding, interactions between traditional and colonial healthcare systems, shaped by religio-cultural beliefs and colonial history in Nigeria.

Perception of Disease Causation and Treatment amongst the Okun-Yoruba People Before Colonisation

The religio-cultural belief in Ase (life forces or spiritual energies) in the Okun-Yoruba concept of ethical monotheism appears to be of controlling significance to disease causation and treatment. The Okun-Yoruba's belief in a supreme being who is the creator of the world and everything in it. They call him Olodumare, which literally translates as the "predestinator or controller of destinies who goes nowhere" [11]. He reigns supreme from Heaven over the earth and the knowledge of the use of herbs as a means of curing diseases originated from heaven. According to oral tradition of the Okun-Yoruba mythology, Ifa was with Olodumare (supreme being), and Ifa was the word, the word was Odu, Odu was God and God was ifa (Odu ifa); ifa was able to know all things [12]. Because he had the wisdom that was beyond understanding, he assumed the role of the diviner. This narrative establishes divination in traditional medicine as a diagnostic tool in Okun-Yoruba culture for seeking spiritual guidance on the causes of illness, misfortunes, and what herbs could be used for treatment nor prayers or ritual could be offered to remedy such imbalance in order to restore harmony and stability of the sick holistically. Okun-Yoruba religio-cultural heritage is associated with countless deities that highlights the vicissitudes of the powers of Olodumare. Ifa, Orishas, ancestors are next in rank to Olodumare, they are spirit guides who serve as intermidiaries between humanity and divinity. Their mode of communication is through divination of Odu Ifa. Okun-Yorubas believe in the potency of Oro (spoken words). It is believed Oro (word) has therapeutic effects. Oro (word theraphy) is used for incantation as a procedure for treatment during divination [12]. It is a form of traditional medical treatment that addresses an illness by the names ascribed to them before their manifestation into the realm of reality through the help of spirit guide. It is a cultural believe that whatever is appropriately called by its real name, would respond appropriately to its call.

The idea of wellness, and illness in the context of disease causation in Okun-Yoruba culture is interwoven in her religio-cultural belief. Ethical Monotheism as a concept in the Okun-Yoruba religio-cultural belief put mans role as a mere instrument of an Almighty power to achieve the ultimate and decisive victory over nature. But in order not to limit mans free will, He admitted the existence of Orishas (guiding spirits) with Ase (energy behind creation) [8] to guide humans in their daily pursuit performed in the spirit of service to the good of humanity. In these regards, Iwa (character or essence) which refers to ones nature, character or moral position must be in alignment with Ase (the energy behind creation). Ase is the spiritual energy that flows through all things. A balance between Ase and Iwa is believed to attract harmony and effectiveness. But whenever Iwa (character or essence) was misaligned with Ase the spiritual energy that flows through all things would be disrupted and that causes disease and other kind of misfortune. In other words Okun-Yoruba religio-cultural belief in the concept of ethical monotheism attributes disease causation to conflict between the external nature (Ase) and the undisciplined human nature (iwa buruku). Out of this struggle disease common to humanity emerges. In this sense the concept of ethical monotheism in the religio-cultural beief of the Okun-Yoruba would often appeal to individual on the basis of his own ethical good. Among the Okun-Yoruba people, iwa (character, good conduct, or nature) was crucial for good health and fortune. Good character (iwa rere) guarantees a balanced life, community harmony, spiritual well-being, sound health and prosperity. While bad character (iwa buburu) attracts misfortune or illness. Moral failings attracts disruption of positive energies (Ase) and attract spell and diseases from harmful spiritual energies.

The Okun-Yoruba people had effective traditional medical practices for the care of the sick interwoven in her religio-cultural belief system. This was significant, so that the culture and the people may be maintained. According to tradition, the Okun-Yoruba people had use these traditional knowledge systems for restoring Ase which is a procedure for holistic healings. These healing procedures are:

First, divination which is a traditional diagnostic techniques is carried out through Odu-Ifa for spiritual guidance to identify and address the points of Ase (life force or spiritual energies) disruptions which is commonly attributed to the cause of diseases or health challenges.

Second, the use of specific herbal treatment for cleansing and rebalancing of the body in order to realign iwa (character) with Ase (spiritual energy).

Third, rituals and prayers in order to realign a sick individual back with his or her spiritual forces for stability and harmony of the soul, body and spirit.

Fourth, offerings and sacrifices to appease Orishas or ancestors.

The mainstream of disease causation and treatment in the traditional knowledge system of the Okun-Yoruba people was established in the concept of ethical monotheism. It was interwoven in a religio-cultural belief of Olodumare as a supreme being whose word was Ifa, endowed in all knowledge, wisdom and understanding of medicinal herbs for treatment of infirmities. Orishas on the other hand play important role in the process of treatment and disease prevention. They serve as guiding spirits and intermediaries between the divine and humans through a unique mode of communication known as Odu-Ifa. Humans have their destinies in their hands to choose their parts to harmony, stability and good health. As Olodumare has given them the free will to choose their paths in life journey. However, humans are expected to live within the moral order of Olodumare (supreme being) by their ethics (iwa). This are conditions that would guarantee an alignment for their harmony, stability and good health through the spiritual energies or life force of their Orishas and Ase (the power that makes things happen/seal of authority).Failings by humans in their individual morals daily creates imbalance between Orishas its Ase (spiritual energy/seal of authority) and its alignment with iwa (character/essence).Out of this struggle between Ase and Orisha and Iwa emerges sickness and misfortune in humanity.

Meanwhile, ethical monotheism as a concept of disease of disease causation and treatment attributes supremacy of creation to Olodumare. He delegates representative responsibilities to Orishas/Ifa for the maintenance of law and order. Since humanity has been given the free will to make their choices through their works of life. Interestingly, every act by individuals character (iwa) must be rewarded accordingly, vengeance came upon evil doers while the beneficent are the instrument of justice and goodness. Orishas interact with humanity as intermediaries to make the divine more accessible. Additionally, diseases are caused by the imbalance between Ase (spiritual energies) of the Orishas and iwa (character/essence) in accordance to the ethical will of Olodumare (supreme being). In unusual instances, sickness or diseases are attributed to curses or spell from evil forces that has disrupted the positive flow of ones Ase (spiritual energy) which was predestined to attract blessing. The remedy for all disruption of all Orishas Ase (deities that makes things happen/spiritual energy) are divination to ascertain the point the disruption occurred by using the traditional diagnostic techniques of Odu-Ifa (special form of communication) between the divine and humanity. Also, by using medicinal herbs for cleansing to restore back balance of Ase (spiritual energy). In many Okun-Yoruba communities there were effective herbal remedies and a broad traditional knowledge on the concept of disease causation and treatment handed down through generations before the pressure that came with colonisation and the interface with western medical care.

Colonial Origin and Motives of Medical Care among the Okun-Yoruba People

The history of Western medical care was apparently a slow, filttering-in process, wave by wave through the colonies of British West Africa. At first, it was tending to the health needs of European colonizers across West African coastal cities such as Lagos and Freetown where white mortality averaged seventy or eighty per one thousand annually in late 1800's, to the interior were colonizers faced much worse, over a long period of time [13]. It was a tumultuous period with high mortality rates among European colonizers. The struggle was prolonged without retreat as a result of European colonial interest. Thus, the main reason for colonization was to secure unfair trade advantages for European firms [14]. Although other motives such as religious conversation and racial discrimination were also prominent [15]. Unfortunately, the main obstacle to these objectives was malaria, which limited military control and threatened all European activities especially in the interior. Hence malaria became a critical threat to European colonial ambition and a major priority for study. British trading firms and chamber of commerce in the late 1800's were leading critics of West African health conditions and harassed the colonial office with complaints about polluted ponds on wells, refuse strewn streets and yards, and open sewage pits as major threats to their own health and the profitability of their business [16]. Joseph Chamberlain the President of the Board of Trade from 1880-1885 was deeply pained by the death rate and economic loss among Europeans upon the West Coast Africa within the period of 1891-1897 [17]. The mortality figure at the period was put at seventy-five, per one-thousand, per annum on the Gold Coast and fifty-three, per one-thousand, per annum in Lagos [18]. The late 19th century saw a turn in the tide. Joseph Chamberlain became the British secretary of State for the colonies in 1895, serving until 1903 [19]. This fearful mortality he would not believe was inevitable and he quoted the case of Calcutta, which used to be known as "the white man's grave" but with improved sanitation and increased knowledge became a healthy and habitable environment in India [20]. Joseph Chamberlain supported policies that benefited Britain's interests, impressing this views of expanding British empire through improved health policies and sanitation on the Governors of various tropical colonies. He admonished Governors of tropical colonies to inform him on measures that could improve the conditions under which white officers lived and was always ready to make funds available in such regards.

In 1890, Jebba was proposed for the headquarters of West African Frontier Force. The colonial office generously advanced the money required for laying out a polo, cricket, tennis ground, and a small race course. Joseph Chamberlain believed anything that would encourage white officers to take exercise also would promote their fitness and health, thereby reduced the risk to fever and other tropical diseases. In addition, the most important step taken by Joseph Chamberlain in this connection was the establishment of the London School of Tropical Medicine in 1899. The idea was suggested by Dr. Patrick Mason, principal medical officer to the colonial office. The school was established in collaboration with Dreadnought Hospital, where they often had considerable size of patients undergoing treatment and after care from tropical diseases. It was a colonial policy that all Doctors taking up appointments

in tropical colonies undergo two months tuition at the school. There they could receive clinical and practical instruction for the prevention and treatment of diseases common with tropical climate and colonies [17]. Under the British colonial health policy, the government also supplemented the grant made by the Royal Society for research enquiry into causes of malaria. Amongst the accomplishment of the London School of Tropical Medicine was the discovery that malaria was conveyed by mosquitoes. Which was demonstrated in the 1890's by Sir Ronald Ross, a British colonial officer in the India medical service [19]. This new ideas and discovery led to renewed policy on European settlements in the colonies, Freetown in West Coast of Africa relocated her white settlement to the Hill top and a new site was also proposed for the capital of Northern Nigeria to Zungeru that was formerly at Lokoja few kilometers to the Okun-Yoruba Kabba Province of Northern Protectorate. Joseph Chamberlain left nothing to chance when it was related to the health of the white settlers in British tropical territories. He urged European permanent officials in the tropical colonies to take full advantage of new scientific medical discoveries on colonies from the London School of Tropical Medicine. This led to Ronald Ross tour around the West African Colonies of Sierra Leone, Gold Coast, and Lagos where he established the, "sanitary squad" at Lagos colony in 1901, focusing on mosquito control and malaria prevention [19]. It was a complimentary plan of the colonial health policy to reduce disease impact on Europeans and improve urban health.

Joseph Chamberlain also gave full support to the colonial nursing association established by Mrs. Piggott to supply trained and skilled nurses to the colonies. Mrs. Chamberlain rose to become the Vice President of the association. All nurses assigned to the tropical colonies were also to receive a special course of training at the London School of Tropical Medicine. It was mandatory before embarking on official deployment to the colonies. These associations provided qualified and brave nurses for the colonial government hospitals of West Africa, most of them served in the West African Frontier Force. For example the Army Hospital at Lokoja established in 1901 as the first administrative headquarters of the British colonial protectorate of Northern Nigeria had nurses supplied by the association before it was moved to Zungeru in 1903 the new administrative headquarters of the Protectorate of Northern Nigeria under the health policy of white settlement of Joseph Chamberlain [21]. Although, Joseph Chamberlain's health reforms led to the establishment of Western medical care and ushered in medical multilateralism in British Colonial West Africa, his reform was not centered on the provision of services and medical infrastructure for the Okun-Yoruba people. But his policies influenced the establishment of Western Medical Care in the tropical colonies of British West Africa. Reverend Tommie Titcombe passed through the London School of Tropical Medicine for the mandatory training of Europeans embarking on a mission to the tropics of Africa. He opened the first Sudan Interior Mission Station at Egbe an interior Okun-Yoruba community at the lower hills of the River Niger in Kabba Province of the Protectorate of British colonial Nigeria in 1908. Missionaries were appendages of the British colonial government. They were answerable to the colonial government whenever the need arises, therefore they were obligated to implement and enforce the policies of British colonial rule. Missionary societies aligned with colonial interest, they established schools, hospitals and medical schools in colonies to train indigenous medical personnels. Reverend Tommie Titcombe, used the daily Sunday school gatherings and weekly bible studies to sensitize his new converts on public health, hygiene, and sanitation in line with colonial health reforms that often superceded traditional practices. The evangelical creed of the Sudan Interior Mission was to minister to both the health and soul of the disciples in the mission field. Tommy Titcombe began his medical missions amongst the Okun-Yoruba people through first aid treatments of ulcers of the indigenous people. Though he offered this services voluntarily with no reward in kind from the people, free of charge. Yet the people were withdrawn to themselves and never patronized him. He had to entice them with gift items, such as tin liquid milk, sugar, and mirrors to buy their attention and time. Gradually, the people got familiar with him. His treatment earned him the name, "Oyibo Oloju", which literally translates as the white man that treats ulcer [22]. But soon as Tommie Titcombe began to enjoy the familiarity of the people, the unification of the colony of Nigeria under Lord Lugard as the Governor General in January 1st 1914 came in with new colonial policy that all Europeans must locate their residence at least four-hundred yards from the villages for health reasons [6]. On the whole, gap in scientific medical knowledge made infanticide cultural practices common amongst some Okun-Yoruba communities. Multiple birth was believed to be a wrath from the gods and such babies are meant to be handed by the father to a traditional priest to be disposed off. In a bid to rescue mothers delivered of multiple birth and their kids, Reverend Tommie Titcombe and his wife Ethel Titcombe made their mission home which was four-hundred yards apart from the indigenous people a maternity and orphanage home were they hid rescued twin. The first twin rescued in Yagba an Okun-Yoruba community was on the 25th of December 1915 [6]. This single act began a full medical mission that led to the establishment of the Sudan Interior Mission Hospital at Egbe Town and the interface between cultural myth in the idea of traditional medicine and western medical care.

The change in paradigm in the idea of medical care and medical multilateralism in the interior of colonial West Africa was solely the efforts of missionary societies. Though the medical department of the colonial office called the colonial medical office was the second biggest personnel branch of the British empire with the colonial medical service employees making up nearly a third of all the colonial service staff. The initial aim of colonial healthcare provision throughout British Africa was the protection and improvement of European health [23]. Historical facts demonstrated that colonial powers promoted medical research and advancements when disease affected their own people [23]. Western medical care had been established on the efforts of European colonialist motives. Overtime, it was developed as a civilizing mission thereby resulting into a clash of civilization. But the British colonial rule often had established ordinances sufficient to contain all forms of resistance

between both contending ideas of medical care. Gradually, with systematic growth in western education with indigenous trained medical personnel; trust on western medical care improved and their benefits became more visible. Coincidentally these cultural and social development was the progressive achievement of multilateralism in medical care among the Okun-Yoruba people of colonial West Africa. There is little or no doubt that western medical care was an instrument of colonisation. According to French colonial strategist, Herbert Lyautey he described Medicine as the most effective of the agents for penetration and pacification [24]. Which rightly summarized the roles and efforts of Joseph Chamberlain, Patrick Mason, and Ronald Ross in the establishment of western medicine through the colonial medical service that transitioning process of medical multilateralism amongst the Okun-Yoruba people of colonial West Africa. As far as the tropical communities of west Africa are concerned, with the Okun-Yoruba people as a research study only few areas have access to western medical services a large proportion of the Okun-Yoruba indigenous people are yet to. This then emphasizes the need to reflect and improve on the effective herbal remedies in traditional medical care for a balanced medical multilateralism.

Challenges, Reactions to the Establishment of Western Medical care among Okun-Yoruba People, and its Interplay in Multilateralism Medical Care

Although traditional medical care and western medical care became two competing philosophies in the idea of medical care with the interface of both ideas under colonisation. But the majority of Okun-Yoruba communities were not privileged to share in the experience of this competing philosophies. British colonial government created a boundary commission that drew arbitrary boundaries and mappings over vast territories under her control without the consent of the indigenous people and putting ethnological factors into consideration. This led to geo-political misrepresentation and marginalisation of the Okun-Yoruba people. The Okun-Yoruba's became a minority group in the Northern Protectorate of British colonial Nigeria as majority of the Yoruba's were in the southwest. Two official languages English and Hausa were adopted for official communication in Northern Protectorate. The majority of the Provinces under the Protectorate of Northern Nigeria could read, speak and communicate in Hausa but the Okun-Yoruba population could neither understand nor speak both adopted official languages. The effects was that all sensitization pamphlets on the workshop and transition to western medical care never benefitted the Okun-Yoruba communities due to the communication barrier. Of course, meaningful change cannot occur within systems designed to uphold colonial and neo-colonial powers.

In the powerful words of Activist Audre Lorde, 'the masters tools will never dismantle the masters house' [25]. The Western medical care established under British colonial policies was highly regionalized certain regions received more or less assistance in developing medical facilities. The development of western medical care was primarily driven by economic interest underpinned by racist political and social system which often led to disastrous consequences. Among this consequence was the uneven development of medical infrastructure. Rural communities, like that of the Okun-Yoruba already geo-politically misrepresented and cut-off by communication barriers never had an British colonial government establish western medical care centers in any of her communities.

It was the Sudan Interior Mission, a missionary society that brought the first western medical care system a maternity hospital to Egbe an Okun-Yoruba community at the lower hills of the river Niger. Perception to maternal health in traditional medical care among the Okun-Yoruba people of Yagba communities and western medical care of the colonialist were at odds. When a mother among the Yagba communities of the Okun-Yoruba gave birth to a baby, the mothers first milk was believed to be full of worms, so for the first nine days she was not allowed to nurse her baby [6]. The baby is sustained by a herbal preparation from the family, lineage or community herbalist with no much sensitivity to hygiene. It was a common believe among the Okun-Yoruba people of Yagba community that a woman who gave birth to twins was something less than human and they would not live any longer in their community [6]. This conflicting ideas in medical care led to the establishment of Egbe Maternity Hospital by Reverend Tommie Titcome and Ethel Titcombe after a messenger came running from the town around five o'clock in the morning to seek their secret assistance to rescue a local woman who just delivered a twin from the cruel custom. The babies were hidden in a calabash and the mother were quietly sneaked at that early hours by Ethel Titcombe to the mission house. That brave act saved the first twin in that community and became the beginning of the interface between traditional medical care and western medical care. Medical missionaries were able to overcome hash confrontations against western medical practice by embedding themselves within local communities, blending their evangelical missions with healthcare provision [26]. Other measures that gave colonialist and missionary societies edge over the subjugation of traditional medical care and the establishment of western medical care was that traditional medical care was not as unified in its methods of diagnosis and treatment ,it was highly regionalized and each indigenous population had its specialized health care. Therefore, all that was needed to breakthrough their ranks was uniform western medical care practices and health policies with the good supervision of colonial resident and district officers and missionaries to impose orders on the ban of certain traditional medical care practices and its practitioners. It was on this premise traditional medical practitioners were branded with derogatory names such as witch doctors and sorcerers and had their activities contained through indirect rule of their communities through its traditional health. Traditional head that could not enforce health policies of the colonialist were deposed.

Ironically, the first world war of 1914 led to difficulties attracting medical personnel to staff colonial healthcare services. There was both limited staff and resources. This weakened British colonial

health policies as most interior communities never had support from the colonial government to establish healthcare centers. Missionary societies became key drivers in the establishment of western medical care centers in most rural areas and western education a policy aimed at training indigenous people to fill in this gaps which began the slow Africanisation of the medical staff in British Colonial West Africa. Missionary schools afford an excellent opportunity for the dissemination of the simple laws of health and by treating school children the confidence of parents became more readily won to the patronage of western medical care services. It is recognized that Western medical care cannot relieve more than a very small fraction of the majority of indigenous Okun-Yoruba people that needs access to good health care. It would be important for traditional medical care system to standardize its practice in order to guarantee a conspicuous presence of goodwill and trust that are vital skill needed for integration of traditional and western medical care as a professional healthcare service. Traditional medical care still remains the first line of primary care across several Okun-Yoruba communities and West Africa at large. Different lines in the philosophy of medical care without integration propels systemic subordination and has distorted the historical purpose of the nature and evolution of medical care.

Conclusion

On the basis of this fact began concurrently the interplay between traditional medical care and western medical care. It was also realized that all ideas of medical care does have its peculiar challenges. Though Western Medical Care has greatly improved in medical services, but it remains a far cry as a health care system that can easily be accessed by the large indigenous Okun-Yoruba communities of Nigeria in West Africa. Which is largely attributed to lean supply of trained medical staff and inadequate resources.

Glossary

Okun-Yoruba	A sub-group of the Yorubas
Olodumare	Predestinator/Supreme God of the Yoruba Cosmology
Iwa	Character/essence
Ifa	Yoruba system of divination
Orisha	Deity
Ase	The force that makes things happen/spiritual energy
Odu	Chapter/Womb
Oyibo Olo'ju	A white man that treat sores or ulcers
Iwa rere	Good character
Iwa buburu	Bad character
Iwa buruku	Bad character
Oro	Word

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