

TACKLING LEPROSY IN COLONIAL NIGERIA, 1926—1960

Author(s): Tunde Oduwobi

Source: *Journal of the Historical Society of Nigeria*, Vol. 22 (2013), pp. 178-205

Published by: Historical Society of Nigeria

Stable URL: <http://www.jstor.org/stable/24768922>

Accessed: 29-03-2017 22:33 UTC

## REFERENCES

Linked references are available on JSTOR for this article:

[http://www.jstor.org/stable/24768922?seq=1&cid=pdf-reference#references\\_tab\\_contents](http://www.jstor.org/stable/24768922?seq=1&cid=pdf-reference#references_tab_contents)

You may need to log in to JSTOR to access the linked references.

---

JSTOR is a not-for-profit service that helps scholars, researchers, and students discover, use, and build upon a wide range of content in a trusted digital archive. We use information technology and tools to increase productivity and facilitate new forms of scholarship. For more information about JSTOR, please contact [support@jstor.org](mailto:support@jstor.org).

Your use of the JSTOR archive indicates your acceptance of the Terms & Conditions of Use, available at

<http://about.jstor.org/terms>



*Historical Society of Nigeria* is collaborating with JSTOR to digitize, preserve and extend access to *Journal of the Historical Society of Nigeria*

# TACKLING LEPROSY IN COLONIAL NIGERIA, 1926–1960

Tunde Oduwobi, PhD\*

## Abstract

The beginning of systematic leprosy work in Nigeria is to be traced to the formation of a branch of the British Empire Leprosy Relief Association (BELRA) in the country in 1928. With BELRA providing much technical expertise through dissemination of the results of medical research, the fieldwork of the programme was carried out by Christian missions on one hand; and, on the other, by local administrations on behalf of the government. The missions provided the personnel and logistics while the local administrations offered financial backing. By the beginning of the 1940s, it had become possible to develop a policy framework for leprosy control. The principal strategy for control and eradication was early diagnosis and treatment of the disease to prevent escalation into the infective stage. Infective patients were segregated through admission into standard leprosaria. Leprosy surveys, therefore, received priority attention for the detection of early infection cases. Through these methods considerable strides were achieved in the reduction of leprosy by the end of the colonial period. This paper examines these developments principally through the utilisation of contemporary sources. The discourse is supplemented by textual secondary material to provide the contextual framework of analysis.

## Historical Background

Leprosy is a disease that disfigures the skin by progressive attrition. For most pre-modern societies leprosy was considered as some

---

\* Tunde Oduwobi can be reached at: [tundeoduwobi@yahoo.com](mailto:tundeoduwobi@yahoo.com)

kind of metaphysical or supernatural affliction that attracted pity or scorn, and leprous persons experienced stigmatisation and varying forms of ostracism.<sup>1</sup> In many African societies the leprous patient was banished into the woods.<sup>2</sup> In Medieval Europe, where biological explanations apart from the metaphysical were adduced, incapacitated and pauper leprosy sufferers were accommodated in almshouses or lazarets.<sup>3</sup> Similar traditions obtained in contemporaneous Islamic cultures where, although religious tenets enjoined shunning leprous patients, these were supported by charitable donations.<sup>4</sup> At all events, the lot of the leprosy sufferer was hardly an enviable one.

As is well known, in 1873 Dr Gerhard Henrik Armauer Hansen, the Norwegian microbiologist identified the *Mycobacterium leprae* as the pathogenic agent in the disease of leprosy.<sup>5</sup> The discovery that leprosy was a bacterial infection had by the turn of the twentieth century led gradually to the view that it was contagious, superseding the earlier notion of heredity propounded by Hansen's Norwegian compatriots, D. C. Danielssen and C. W. Boeck in the 1840s.<sup>6</sup> However, in the face of the resistance of *Mycobacterium leprae*

<sup>1</sup> For a concise explication of biblical representation of leprosy and its influence on social attitudes, see Michael Mizell-Nelson, 'Treated as Lepers: The Patient-Led Reform Movement at the National Leprosarium, 1931–1946', *Journal of the Louisiana Historical Association*, 44 (2003): 302–304, *et passim*. Needless to say, the literature on this subject is fairly large. Anthropologists working in colonial Nigeria encountered societies, which held the belief that leprosy could be inflicted on a victim as a curse. Cf. S. Milburn, 'Magic and Charms of Tjebu Province, Southern Nigeria', *Man*, 32 (1932): 159; H. O. H. Vernon-Jackson, 'A Leprosy Transmission Belief amongst the Angas in Northern Nigeria', *Man*, 61 (1961): 55–56.

<sup>2</sup> The practice encountered in the Belgian Congo (Democratic Republic of Congo) by S.G. Browne is typical and illustrative. S. G. Browne, 'Leprosy,' in E. E. Sabben-Claire, D. J. Bradley, and K. Kirkwood (eds.), *Health in Tropical Africa during the Colonial Period* (Oxford: Clarendon Press, 1980), 75–76.

<sup>3</sup> Luke Demaitre, *Leprosy in Premodern Medicine: A Malady of the Whole Body* (Baltimore: The Johns Hopkins University Press, 2007), *passim*.

<sup>4</sup> See Michael W. Dols, 'The Leper in Medieval Islamic Society', *Speculum*, 58 (1983): 891–916.

<sup>5</sup> For a biographical sketch, see 'The Discoverer of the Leprosy Bacillus', *British Medical Journal [BMJ]*, 2 (1901): 494.

<sup>6</sup> On Danielssen and Boeck's work, see Rod Edmond, *Leprosy and Empire: A Medical and Cultural History* (Cambridge: Cambridge University Press, 2006), 45.

to cultivation *in vitro* and the attendant failure of inoculability, there were rival views canvassing non-human vectors, especially insects. One other notable dissenting variant connected infection with food ingestion. Jonathan Hutchinson, (president of the Royal College of Surgeons in 1889), held that infection resulted from the consumption of putrid or decaying fish;<sup>7</sup> or more generally, through food contamination by the leprosy sufferer—an act resulting from what he called ‘commensal communication’.<sup>8</sup> This fear of infection through food ingestion was reflected in colonial official statutes, which contained clauses prohibiting leprosy sufferers from the sale of edible substances. However, the view that gained greater currency was that the transmission of the *Mycobacterium leprae* bacillus was either through nasal inhalation or skin openings from prolonged close contact with a human host. Infection was therefore most likely to occur within a family or household setting.<sup>9</sup>

One peculiarity of leprosy was its incurable nature through the ages. Claims of Western medicine, especially during the last quarter of the nineteenth century, of a cure proved ephemeral as hardly any leprosy patient was healed of the disease. It was a period, to use Sanjiv Kakar’s words, ‘of experimenting with new treatments which promised but invariably withheld the prospect of cure’.<sup>10</sup>

By the last quarter of the nineteenth century Asia and the Far East had come to be associated with high leprosy prevalence;<sup>11</sup>

<sup>7</sup>. See ‘Leprosy: Its Etiology, Histology, and Treatment’, *BMJ*, 2 (1903): 701–704.

<sup>8</sup>. Replying to remarks by critics that commensal communication was some form of contagion, Hutchinson responded with characteristic sophistry: ‘Undoubtedly it is, as I have often termed it, personal communication. There are, however, differences between contagion by touch, clothes, etc., and the introduction of a virus’. *BMJ*, 2 (1903): 1014.

<sup>9</sup>. This perhaps explains the erroneous conception of the disease as hereditary. A Colonial Office circular stood this argument on its head in stating that ‘the fact that leprosy is transmitted from parent to child is indisputable, and ... leprosy by descent is often through a natural error mistaken for leprosy by contagion (the members of one family being naturally in contact)’. Earl of Kimberly to Colonial Governments, 4 September 1873, cited in Edmond, *Leprosy and Empire*, 65.

<sup>10</sup>. Sanjiv Kakar, ‘Medical Developments and Patient Unrest in the Leprosy Asylum, 1860–1940’, *Social Scientist*, 24 (1996): 71.

<sup>11</sup>. Zachary Gussow and George S. Tracy, ‘Stigma and the Leprosy Phenomenon: The Social History of a Disease in the Nineteenth and Twentieth Centuries’, *Bulletin History of Medicine*, 44 (1970): 433–39.

and in the circumstances, 'leprosy's continuing incurability', as Kakar notes, 'bred an openness towards indigenous treatments'.<sup>12</sup> In this context, modern advances in the treatment of leprosy can be traced to the increasing popular use of chaulmoogra oil from the early decades of the twentieth century. The chaulmoogra (*Hydnocarpus*) tree was indigenous to the Far East, especially Southern India and Myanmar. Oils extracted from the seeds of the fruit were taken orally or applied topically to the leprous parts of the body. However, the nauseating smell and taste of the oil often discouraged the patient from administering effective doses.

Two of the many species of the chaulmoogra tree became popular in the treatment of leprosy, namely: *Hydnocarpus kurzii* and *Hydnocarpus wightianus*. In 1913, V. G. Heiser (in the Philippines) experimented with intradermal and intramuscular injections using oil extracted from the former. He mixed the oil with camphor and resorcin in order to obtain a less viscous or thinner fluid substance. This was taken over in the course of the next two years by Sir Leonard Rogers (in India) who isolated the active ingredients (fatty acids) of the oil and converted them into a sodium-based soluble compound. This he applied intravenously, a method he found of greater therapeutic value than the intradermal and intramuscular modes. The intravenous mode, however, had the disadvantage of being more painful and causing vein irritation and blockage if administered improperly. Intradermal and intramuscular hypodermic procedures were also adopted by H. T. Hollmann and A. L. Dean (in Hawaii) who, taking cues from Heiser and Rogers, converted fatty acids of the oil into ethyl esters (thin oils).<sup>13</sup> The ethyl esters were, however, more expensive. In the early 1920s they were commercialised by Burroughs Wellcome under the brand name of Moogrol. By 1920, Rogers had identified *Hydnocarpus wightianus* to be more effective. This was likewise converted into a sodium-based soluble

<sup>12</sup> Sanjiv Kakar, 'Leprosy in British India, 1860–1940: Colonial Politics and Missionary Medicine', *Medical History*, 40 (1996): 216.

<sup>13</sup> For these developments, see Ernest Linwood Walker and Marion A. Sweeney, 'The Chemotherapeutics of the Chaulmoogric Acid Series and Other Fatty Acids in Leprosy and Tuberculosis', *Journal of Infectious Diseases*, 26 (1920): 238–43.

compound and manufactured by Burroughs Wellcome in 1927 under the brand name of Alepol, which because of its additional analgesic properties had the advantage of removing injection pains and the adverse effects on veins.<sup>14</sup> The chaulmoogra therapeutic treatment remained popular till the 1940s; although its efficacy was considered doubtful by certain contemporary medical authorities.<sup>15</sup>

For a disease which brought pariah status on its victim in the society and with little significant record of permanent cures until relatively recently, leprosy attracted varying approaches of containment and control during the imperial era. Rod Edmond has summed up the general position concisely:

Compulsory segregation...became widespread in the later nineteenth century, and even then there was variation across the imperial world. In most parts of Africa colonial governments lacked the resources to enforce segregation, and in India the scale of the problem defied any such policy. The most rigorous application of the compulsory segregation of lepers occurred in smaller colonies with higher proportion of European settlers. Many of these were island colonies in the Caribbean, Pacific and Indian oceans, or coastal ones such as the Cape Colony or around the fringe of the island continent of Australia.<sup>16</sup>

In other words, it was the incidence of numbers that broadly determined the method by which the disease was contained. As a corollary, direct government intervention was characteristic of settings, which afforded enforced segregation. Meanwhile, voluntary bodies were the key actors in areas where it was difficult to implement that policy. The works of Jane Buckingham and Ranjiv Kakar on India demonstrate that Christian missions initiated the programme of action there.<sup>17</sup> The missions were active too in

<sup>15</sup>. G. W. McCoy, 'Chaulmoogra Oil in the Treatment of Leprosy', *Public Health Reports*, 57 (1942): 1727-33. For such other dissenting opinions see the *BMJ*, 2 (1926): 1141, 1195-96; 1 (1927): 40, 401.

<sup>16</sup>. Edmond, *Leprosy and Empire*, 143.

<sup>17</sup>. Jane Buckingham, *Leprosy in Colonial South India: Medicine and Confinement* (New York: Palgrave, 2002); Kakar, 'Leprosy in British India, 1860-1940', 215-30.

Nigeria as exemplified by the studies of C. N. Ubah on Igboland, and K. O. Kalu and John Manton among the peoples of the Cross River basin, all in Southeastern Nigeria.<sup>18</sup> With Kano as a case study, this dimension has also been explored by Shobana Shankar through a consideration of the socio-political implications of Christian missionary leprosy work among the Muslim-dominated societies of Northern Nigeria.<sup>19</sup> The consensus in the literature is that the activities of the missionaries were motivated by both humanitarian and spiritual considerations. As Worboys writes, ‘the aims of medical missionary work...were to continue the work of Christ the healer...to provide an opening into alien cultures to facilitate conversions and to represent the superiority of Western civilization’.<sup>20</sup>

Of equal importance in the contributions made by voluntary organisations was the role played by the British Empire Leprosy Relief Association (BELRA) in initiating the awareness campaign for leprosy control. BELRA developed the theoretical framework and strategy for the containment of the disease. It provided material support for the missions and solicited the government for respectable financial commitments in the fight against leprosy. This article considers attempts at controlling the incidence of leprosy in colonial Nigeria: it was a three-pronged affair involving the

<sup>18</sup> C. N. Ubah, ‘Hope for the Despondent: A Colonial Health Care Scheme at Uzuakoli, Eastern Nigeria’, *Transafrican Journal of History*, 21 (1992): 51–58; K. O. Kalu, ‘Beauty for Ashes: Presbyterian Leprosy Work in South-Eastern Nigeria, 1926–56’, in Ogbu U. Kalu (ed.), *A Century and Half of Presbyterian Witness in Nigeria, 1946–1996* (Lagos and Enugu: Ida-Ivory Press, 1996), 193–219; John Manton, ‘Administering Leprosy Control in Ogoja Province, Nigeria, 1945–67: A Case Study in Government-Mission Relations’ in David Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam: Rodopi, 2006), 307–31.

<sup>19</sup> Shobana Shankar, ‘Medical Missionaries and Modernizing Emirs in Colonial Hausaland: Leprosy Control and Native Authority in the 1930s’, *Journal of African History*, 48 (2007): 45–68; Shobana Shankar, ‘The Social Dimensions of Christian Leprosy Work among Muslims: American Missionaries and Young Patients in Colonial Northern Nigeria, 1920–40’ in David Hardiman (ed.), *Healing Bodies, Saving Souls*, 281–305.

<sup>20</sup> Michael Worboys, ‘The Colonial World as Mission and Mandate: Leprosy and Empire, 1900–1940’, *Osiris*, 2<sup>nd</sup> Series, 15 (2000): 209.

Christian missions, government agencies, and BELRA. The paper examines the extent to which these three major strands interfaced to address an important health issue in the country during the colonial period.

### **The BELRA Initiative**

In British tropical Africa the campaign against leprosy was pioneered by BELRA, which was inaugurated in 1924 with Sir Frank Carter, Sir Leonard Rogers and Mr. Frank Oldrieve as its principal initiators.<sup>21</sup> The aim of the association was to promote awareness of the new treatment methods for combating leprosy with a view to ultimately eliminating the disease. The British Empire was central to this crusade as its dependencies were estimated to have the highest global prevalence of the disease. The association's primary strategies were to: (i) enlist the support of colonial governments in its campaign; (ii) provide charitable assistance; (iii) chart a blueprint for leprosy control. It was in furtherance of these objectives that Frank Oldrieve, the secretary of the association, arrived in Nigeria as part of a wider tour of British West Africa in January 1926. Specifically, he was to assess the situation and then persuade the government to support the establishment of a local branch of the association.<sup>22</sup>

Previous enactments in the country relating to leprosy were the Lepers Ordinance of 1908 of the Protectorate of Southern Nigeria and the Lepers Proclamation of 1911 of the Protectorate of Northern Nigeria.<sup>23</sup> The former made the establishment of leprosy asylums the concern of the government, while the latter placed it under the

---

<sup>21</sup>. Preliminary arrangements for the formation of the association began in July 1923.

<sup>22</sup>. For Frank Oldrieve's visit, see CSO 26/3, file no.20902, vol. I, National Archives Ibadan (NAI).

<sup>23</sup>. In May 1906, the Lagos Colony and Protectorate administration was amalgamated with its eastern neighbour, the Protectorate of Southern Nigeria to become the Colony and Protectorate of Southern Nigeria. The administration of the Protectorate of Southern Nigeria enacted the Lepers Proclamation in 1904, which metamorphosed as the 1908 Lepers Ordinance of the amalgamated administration of Southern Nigeria.



jurisdiction of the local authorities (Native Administrations as they were called). In practice, however, little was achieved. As Shankar has written regarding the implementation of the northern legislation, the proclamation resulted in no more than the construction of lazarets or almshouses. The inmates were usually mendicant leprosy sufferers induced to come under segregation by doles from the local authorities as alms sanctioned by Islamic tenets.<sup>24</sup> In the south, a sole government asylum was established in Lagos in 1908, but was hardly functional. It had no permanent medical superintendent; being served only by the weekly visits of the Director of the Medical Research Institute. In 1926, it had fifteen inmates!<sup>25</sup>

The south and the north were amalgamated to form a single administration in 1914, but both regions continued as administrative blocs styled Southern Provinces and Northern Provinces. In 1916 the Leprosy Ordinance was promulgated, which had countywide application and replaced the two earlier laws for the south (1908) and north (1911). Although the new law retained the *modus operandi* of its twin predecessors, central government policy generally drifted towards the practice inherited from the north. Again, the new law, like its predecessors, did not compel segregation, except to state that a leprosy patient was 'a source of danger to public health'.<sup>26</sup> Against a background of the prevailing uncertainty of the manner of infection of the disease—through either contagion or ingestion—the ordinance generally placed restrictions on the public contacts of leprosy sufferers. Thus, the leprosy sufferer was not to be engaged as a 'baker, butcher, cook, fishmonger, washer, bootmaker, tailor, barber, domestic servant, nurse, dairyman'.<sup>27</sup> In other words, the leprosy sufferer was to abstain from vocations involving direct or indirect skin contact as well as the handling of edible substances. In the areas reserved for

<sup>24</sup> Shankar, 'Medical Missionaries', 50–53.

<sup>25</sup> Frank Oldrieve, 'Report on the Leprosy Problem in Nigeria', 20 February 1926, CSO 26/3, File no. 20902, vol. I, National Archives Ibadan.

<sup>26</sup> *Laws of Nigeria*, 1923, Cap. 52, sec. 8.

<sup>27</sup> *Ibid.*, Schedule, 71.

European residence, described in the ordinance as 'proclaimed districts' ostensibly established to protect European vulnerability against diseases from Africans, the leprosy sufferer (usually a menial worker) was under strict observation and much more liable to compulsory segregation.<sup>28</sup>

The approximate figures available for the Northern Provinces at the time of Oldrieve's arrival certainly indicated a high leprosy rate in the country. In a population of about ten million in the Northern Provinces, there was an estimated number of 32,772 leprosy sufferers, representing an incidence of 3.2 per thousand. This was ten times higher than that of India which, with a leprosy population of 102,000 in a country of 319 million, was 0.32 per thousand.<sup>29</sup> Statistics were lacking for the Southern Provinces but the extent of the problem, especially in its eastern sections (Eastern Provinces from 1938), began to emerge from 1928 when the country's principal medical officer reported that those 'who know the [area] well assess the number at not less than 100,000'.<sup>30</sup> Events of the 1930s and 1940s were to bear out the veracity of this statement on the huge numbers of leprosy sufferers in the Eastern Provinces.

Given these high figures, financial constraints ruled out a policy of compulsory segregation. Those who submitted to voluntary

---

<sup>28</sup>. *Ibid.*, sec.6 and Regulations under Section 21(e), 339. It has been argued that racial rather than health considerations underlined the policy of European reservation areas begun by Governor General Lugard (1914–18). Lugard, writes T. S. Gale, 'was the only governor in British West Africa to adopt a policy of compulsory segregation...Lugard began in 1914 to designate European reservations separated from the African section in each town by a 440-yard neutral zone'. See Thomas S. Gale, 'Lord F. D. Lugard: An Assessment of His Contribution to Medical Policy in Nigeria', *International Journal of African Historical Studies*, 9 (1976): 636–37. The subsequent development of the policy has been examined by Ayodeji Olukoju, 'The Segregation of Europeans and Africans in Colonial Nigeria' in Laurent Fourchard and Isaac Olawale Albert (eds.), *Security, Crime and Segregation in West African Cities since the 19th Century* (Ibadan: IFRA, 2003), 264–86.

<sup>29</sup>. Oldrieve, 'Report on the Leprosy Problem in Nigeria'.

<sup>30</sup>. Director of Medical and Sanitary Service to Secretary to the Government, 27 January 1928, CSO 26/3, File no. 20902, vol. II, National Archives Ibadan.

segregation were usually mendicant leprosy sufferers, who in the north as already mentioned were attracted by allowances from the local administration. Since the disease generally defied treatment, segregation without the promise of health relief was considered simply as confinement by leprosy sufferers. They were therefore apt to conceal their affliction for as long as it was possible to avoid this fate. A policy of leprosy control truly began from the 1920s following the introduction of the chaulmoogra derivatives. The prospect of a cure brought about an enthusiasm in addressing the leprosy problem. In this connection, Oldrieve noted that hitherto there was 'the feeling among medical men that any work that was attempted was not very effective'.<sup>31</sup>

At the end of his tour of the country in February 1926, Oldrieve recommended the formation of a local branch of the BELRA as marking a beginning in confronting the leprosy scourge. He proposed a membership structure which, like that of the parent body, reflected the association's desire to solicit official support for its cause. The patron of the parent body was a member of the British royalty, the Prince of Wales, while the vice presidents were important colonial officials and governors.<sup>32</sup> This arrangement was to be simulated in the Nigerian environment by the appointment of the governor as president of the local branch, while the vice presidents were to be high-ranking officials of the government and a number of eminent local rulers. Like their counterparts in the parent body they were honorary members. The more active segments of the parent body were the general and executive committees. Their Nigerian counterpart was to be the central committee with two subordinate committees styled Northern Committee and Southern Committee representing, respectively, the interests of the Northern Provinces and the Southern Provinces. Oldrieve's idea was that the central committee would function as a think-tank as well as provide an avenue for assistance to the government on leprosy control in the country.

<sup>31</sup>. Oldrieve, 'Report on the Leprosy Problem in Nigeria'.

<sup>32</sup>. In deed, in 1937, King George VI (1936–1952) became the association's patron. *BMJ*, 1 (1937): 864.

Things, however, were to turn out differently. The government had no intention of being the principal financial sponsor of the leprosy cause. When in November 1928 the Nigerian Branch of the British Empire Leprosy Relief Association was inaugurated it was made up of a General Committee and an Executive Committee. The General Committee was in fact the plenary body of the branch comprising the governor as the chairman and several other important dignitaries from government and non-government circles as members. Its role turned out to be no more than symbolic and ceremonial. Thus, after the branch was inaugurated in 1928, the next and last time the General Committee was convened was in May 1936 on the occasion of the visit of E. Muir, the secretary of the parent body.

The Executive Committee was made up of government officials with the Director of the Medical and Sanitary Service Department as chairman. The non-official membership comprised a member of the Legislative Council, a representative of the British Bank of West Africa, and the secretary. The secretary was to be a leprosy officer equipped with a secretariat and who through tours would provide first-hand assessment of leprosy work in the country and offer advice and policy recommendations. He was to be employed by the parent body, although his salary and expenses for running his secretariat were in the interim to be defrayed by the government. Dr T. G. F. Mayer, who was appointed in March 1928 as the leprosy officer, was a former official of the country's medical service.<sup>33</sup>

Ideally the branch was expected to raise its funds and aim at financial autonomy. But this was not to be the case as it made unsuccessful attempts to solicit the sponsorship of a number of commercial concerns in the country, and was therefore unable to generate additional funds from non-government sources like the parent body. In the event, the Executive Committee came under the direct charge of the Medical and Sanitary Service Department and operated within its budgetary provisions. It was therefore to

---

<sup>33</sup>. See CSO 26/3, File no. 20902, vol. II, National Archives Ibadan.

the chagrin of Mayer when a grant of £500 received from the central body in December 1930 was credited to the government accounts. In desperation the secretary proposed the establishment of central regional funds by the Northern Provinces and the Southern Provinces into which their respective Native Administrations were expected to make contributions. Such regional funds, he argued, would enable the Executive Committee of the local BELRA to properly coordinate the leprosy work in the country. But, here again, he met with stiff opposition particularly from the officials of the Northern Provinces.

Always priding itself as the custodian of Indirect Rule as enunciated by Lord Lugard, the Northern Nigerian administration was conservative and isolationist. It held that the administrative independence of indigenous authorities, under the guidance of local British officials, should be preserved. It was ever sceptical of any centralist policy, such as suggested for the Executive Committee by Mayer, which might circumscribe the powers of the chiefs with regard to decisions concerning their areas of jurisdiction.<sup>34</sup> The government's preference too was for the branch to support itself on non-official sources. As a result, it supported the Northern administration with the ostensible argument that:

Subscriptions by Native Administrations...to a general fund should be avoided [because] in their present stage of development the people wish tangible proof that their money is being spent on themselves, and are unable to appreciate the merits of a Central Fund, even for such desirable object as Leprosy Relief. The wider outlook may come to them in due time, but in his Excellency's opinion it is idle to expect it at present and indeed wrong to attempt to apply pressure in a manner which may retard the very development which is our concern.<sup>35</sup>

<sup>34</sup>. On attitudes of Northern Nigerian officials to central policies in Nigeria, see J. J. White, *Central Administration in Nigeria, 1914–1948* (Dublin: Irish Academy Press, 1981), 59–82; and Tunde Oduwobi, 'From Conquest to Independence: The Nigerian Colonial Experience', *Historia Actual Online*, 25 (2011): 19–29.

<sup>35</sup>. Ag. Chief Secretary to the Government to Secretary, Northern Provinces, 30 September 1930, CSO

Feeling frustrated, Mayer constantly clashed with the officials of the medical and treasury departments as he considered that government could do more than the annual commitment of just over £8000 for leprosy relief work of which more than 40 per cent was spent on his salary and the secretariat. The climax came in February 1931 when the government dispensed with his services on grounds of financial expediency resulting from the prevailing global economic recession. With the removal of the leprosy officer, an official of the medical department was appointed as the secretary of the local BELRA with strictly clerical duties.

### **Christian Missions and Native Administrations**

In so far as the wider aims of BELRA were concerned, Mayers' three-year stay in the country achieved very little. He was of course an important medium in the provision of drugs and dissemination of literature by BELRA. Also, through his tours he was able to produce a mapping of the prevalence of leprosy in the country in anticipation of surveys to determine the design of leprosy work. However, his attempt to initiate a structural framework foundered against the binary political configuration of the Nigerian system of juxtaposition between the northern administration on one hand and the southern and central administration on the other.

More important was the issue of financial limitations. As long as the prevalence of leprosy did not reach dangerously pandemic proportions or threaten the health of the European colonial class, the government found it unnecessary to accord special considerations to the disease in the country.<sup>36</sup> Unlike some other tropical diseases like malaria and bilharzia, leprosy infection was not immediately fatal; it only had the long term effect of shortening the life span of the sufferer. Again, contemporary medical opinion acknowledged that leprosy was not highly infectious, and encouraging results were obtained from the treatment of early stages of the disease. Such perceptions persuaded the government to call upon the Native Administrations to play a greater role in leprosy control on its behalf through substantial contributions to

---

<sup>36</sup> For earlier similar developments in India, see Kakar, 'Medical Developments', 64–67.

the running of a number of leprosaria in the country. Government's position, as an official described it in 1932, was that leprosy control 'was essentially a domestic [local] service'.<sup>37</sup> The government owned only one institution, the Yaba Leper Asylum, at the capital in Lagos; and until the end of the decade government's annual expenses on leprosy work in the country was below £5,000.

The landscape was expanded by the role of Christian missions. In his tour of the country in 1926, Oldrieve, apparently contrasting the position in Nigeria with that in India, observed that 'missions have not done anything much to deal with the leper'.<sup>38</sup> Incidentally, it was from that year that the missions became actively involved in leprosy work. Rapid progress followed in a short spell to the point that out of a total of 2,670 leprosy sufferers reported to be receiving treatment in 1929, the missions had 1,503 cases.<sup>39</sup>

The pace was set by the Church of Scotland Mission (Presbyterian), which established a leprosarium with very modest beginnings at Itu in the Calabar Province in 1926 under Dr Macdonald. It all began with the treatment of leprosy sufferers who visited the mission dispensary under Macdonald, and since it was known that faster results could be achieved with in-patients he began a leprosarium by asking his patients to give three days' service in lieu of admission fees for the erection of building structures. A colony was in no time established and when in April 1928 Mayer visited the settlement there were as many as 400 in-patients. By the next year, the number had increased to 900; and by 1933 to over 1,200. It also grew as a social and industrial colony as many of the patients supported themselves by engaging in such vocational crafts as canoe-making, carpentry, blacksmithing, making of fishing nets as well as farming. Some of the patients were also engaged as law-enforcement personnel with uniforms

---

<sup>37</sup>. Ninth Meeting of the Executive Committee [of the local BELRA], 23 August 1932, CSO 26/3, File no., 20902, vol. V, National Archives Ibadan.

<sup>38</sup>. Oldrieve, 'Report on the Leprosy Problem in Nigeria'.

<sup>39</sup>. Minutes of Meeting of the Executive Committee, 12 March 1929; Minutes of Meeting of the Executive Committee, 19 July, 1929, CSO 26/3, File no., 20902, vol. IV, National Archives Ibadan.

to maintain law and order in the community. In recognition of the extensive progress recorded at the leprosarium, the government commenced the payment of a grant of £500, through the local BELRA, for Macdonald's salary.



Other missions soon began to follow the trend started by the Church of Scotland Mission at Itu. A principal one was the Church of the Brethren Mission that established a settlement centre at Garkida in Adamawa Province in 1929. Starting with just nine patients, the number increased to 200 by 1931, and during which period it received some grants from BELRA. The Methodist Mission also commenced an effort in Ilesa (Oyo Province) after a grant of £100 from BELRA. In a similar manner, 'Christian Mission in Many Lands' under Dr Newstone started a settlement at Otukpo (Benue Province) in 1929 with a grant from BELRA. Other missions that got involved were the Dutch Reformed Mission in the Benue Province and the Sudan Interior Mission (SIM) in the provinces of Bauchi, Niger and Plateau.

Native administrations began also to either upgrade or consolidate existing leper camps into organised leprosaria. Thus, for example, a new leprosarium was constructed at Ossiomo in the Benin Province in 1932 to which were transferred patients of



the eight existing leper camps in the province. Assistance came from the Roman Catholic Mission through the provision of medical missionary personnel (Lady Dr Louba Langauer and Father Hugh Colon) to manage the new leprosarium. Similar developments led to the establishment of a leprosarium at Uzuakoli, Owerri Province, under the management of the Methodist Mission in 1932. By 1936 Native administrations owned leprosaria in Oji River (Onitsha Province), Katsina (Katsina Province) and Sumaila, which was relocated in December 1937 to Yada Kunya (Kano Province).<sup>40</sup> These, too, came to be administered by Christian missionary doctors.

The central organisation of BELRA hoped to play a systematic role in these developments beyond offering grants. In 1933, it impressed on the government the need for a leprosy officer, as was the case with Mayer, for proper coordination of leprosy work and control in the country. Since the government attributed financial reasons for dispensing with the services of the leprosy officer in 1931, BELRA promised to defray half of the salary of a new one up to a maximum of £500 for three years. The government declined this arrangement. It contended that there was now considerable awareness of leprosy control and that in view of the still lean finances of the government, the employment of a leprosy officer was a luxury it could ill afford.<sup>41</sup> It explained that leprosy

---

<sup>40</sup> For these developments see, Mayer's Report on a Tour through the Southern Provinces of Nigeria in Connection with the Work of Leprosy Relief, 1928, CSO 26/3, file no. 20902, vol. III, National Archives Ibadan; and Report on a Tour through the Southern Provinces of Nigeria in Connection with the Work of leprosy Relief, 1929, CSO 26/3, file no. 20902, vol. IV, National Archives Ibadan; Minutes of Meeting of the Executive Committee, 12 March 1929; Minutes of Meeting of the Executive Committee, 19 July, 1929; E. Muir, *Leprosy in Nigeria, A Report of Anti-Leprosy Work in Nigeria with Suggestions for Its Development* (Lagos: Government Printer, 1936), 17–26; Ralph Schram, *A History of the Nigerian Health Services* (Ibadan: University of Ibadan Press, 1971), 230–6; S. G. Browne, 'Leprosy', 70–74.

<sup>41</sup> E.A. Gait to Secretary of State for the Colonies, 12 June 1933, enclosure in Secretary of State for the Colonies to Governor, Nigeria, 26 June 1933; Director of Medical and Sanitary Service to Chief Secretary to the Government, 24 July 1933; Acting Chief Secretary to the Government to Director of Medical and Sanitary Service, 14 September 1933, CSO 26/3, File no. 20902, vol. V, National Archives Ibadan.

work now devolved on native administrations and missions with government support and that what was required was increased medical personnel so that many more settlements could be established. It, therefore, suggested that the Kano Native Administration that was about to establish a leprosarium take up the offer.

This was not the desire of BELRA. The association wanted a medical technocrat who would coordinate the country's leprosy work, not a medical officer managing a leprosy settlement. It, nonetheless, acceded to the government's proposition since it was still part of leprosy work in the country, but reduced its commitment of three years to eighteen months in defraying half of the salary of the proposed officer. Dr A. C. Howard was appointed on this basis in June 1934 and at the end of eighteen months, in December 1935, the Kano Native Administration took full responsibility for his salary. He was, however, subsequently integrated into the government medical service and deployed for more general health duties in the province.<sup>42</sup>

Simultaneous with these developments were moves made in conjunction with BELRA to support leprosy work in the country by Toc H, the volunteer welfare organisation of the Rev. P. B. Clayton. Late in 1933 the two bodies made a joint offer to sponsor trained auxiliaries to work in various leprosaria in the country for a period of five years. These men finally arrived on 4 July 1935 and were posted as follows: Lambert (Kano); Pedrick (Maiduguri); Crayford (Katsina); Parker (Onitsha); Macgregor (Itu). Before proceeding to their stations all of them were taken to Itu where they received a two-week further training under Macdonald.<sup>43</sup> On his arrival in the country the previous year, Howard had taken similar instructions and training at Uzuakoli, Itu, and Ossiomo before proceeding to his station in Kano.<sup>44</sup>

---

<sup>42</sup>. Secretary Northern Provinces to Chief Secretary to the Government, 23 December 1935, CSO 26/3, File no. 20902, vol. V, NAI.

<sup>43</sup>. Alex Fiddian to Chairman, Executive Committee, BELRA, 25 April 1934, CSO 26/3, File no. 20902, vol. V, NAI; Ag. Director of Medical and Sanitary Service to Chief Secretary to the Government, 13 June 1935, same file.

<sup>44</sup>. Secretary, BELRA to Under Secretary of State, 25 June 1934, CSO 26/3, File no. 20902, vol. V, NAI.

### Containment and Funding

As earlier mentioned, in 1936 the General Committee of the local BELRA was convened to receive E. Muir, the secretary of the patron association. He was in the country as part of a tour to West Africa to assess the level of leprosy work since the formation of local branches of the association in the past decade. Muir visited various leprosaria in the country in April and May. In his report at the end of the tour Muir considered that there was still much room for improvement. With a leprosy population estimated at over 200,000, less than 6,000 were managed in the various leprosaria all together. Unfortunately, effective leprosy control was defeated by the fact that quite a proportion of the patients were those beyond the infective stage and permanent cure.<sup>45</sup> For proper leprosy control there was the need to establish the idea that leprosy settlements were treatment centres (leprosaria) and not almshouses (lazarets). 'While sheltering and providing for these unfortunate people is to be highly commended as an act of charity', he submitted, 'it is of little or no value from the public health point of view'.<sup>46</sup> For humanitarian considerations, therefore, it might be necessary to establish lazarets for pauper and non-infective leprosy sufferers.<sup>47</sup> This would be within the context of establishing a discriminatory process by which more of the infective cases were identified for admission in the leprosaria. As a corollary, it would be important to identify, through surveys, cases at the incubation stages and, as these were more amenable to cure, prevent them from transiting to the infective stages. In other words, the control strategy should

---

<sup>45</sup>. As was understood, there were two principal types of leprosy: the nodular, characterised by ulcerating skin eruptions affecting the head, face, and ears especially; and the neural, which caused sensory loss of body parts. The period of most vulnerability to infection was between childhood and young adult years, with an incubation period of three to five years. After the period of incubation the leprosy sufferer became infective for about ten years or more. Treatment had greater chances of success during the incubation and infective stages.

<sup>46</sup>. Muir, *Leprosy in Nigeria*, 3.

<sup>47</sup>. At the annual meeting of BELRA held in 1943, the need was stated for 'separate institutions for those who had passed through the contagious stage but were too old or feeble to work, and who took up room in hospital, which was wanted for cases needing more urgent treatment'. *BMJ*, 2 (1943): 8.

be to identify and cure pre-infective cases, and, segregate and treat infective cases. Those in the incubation or pre-infective stages could be managed as outpatients, while those in the infective stages should be taken up by the leprosaria.

Muir was, in fact, expounding BELRA's blueprint on leprosy control strategy as articulated by Rogers since the early 1920s.<sup>48</sup> To actualise this process, Muir—in apparent recognition of the government policy that the native administrations were to be the fulcrum of the country's leprosy work—recommended the establishment of a principal leprosarium in every province. Contiguous provinces could jointly own one if the incidence of leprosy was low in their areas. The provincial leprosarium was also to serve as some kind of training centre for auxiliary leprosy workers. Associated with each provincial leprosarium were to be a number of satellite leprosy settlements formed by groups of communities in the province. The provincial leprosarium should contain the infective cases; and it should also have a section for children to keep them away from being infected by their parents. This was most crucial as children were the most susceptible to the *Mycrobacterium leprae* infection. The satellite settlements were to be managed by trained auxiliary leprosy workers and were to receive frequent visits from the medical personnel of the parent leprosarium. These settlements would provide avenues for the detection of early infection as well as the identification of infective cases. Muir noted that the chaulmoogra derivatives remained the standard treatment remedy, but observed the need for medical personnel to be better acquainted with the dispensing of the drugs to obtain the best results. He commended on-going efforts at growing the plants locally, suggesting methods of improvements towards having sufficient local production to enable price affordability.<sup>49</sup> He stressed the need for improved laboratory

---

<sup>48</sup>. Leonard Rogers, *Memorandum on the Prevalence of and Prophylaxis against Leprosy in the British Empire, Based on replies to the Questionnaire of the British Empire Leprosy Relief Association with Suggestions for Dealing with the Problem* (Lagos: Government Printer, 1925), 1–18.

<sup>49</sup>. Cf. J. D. Kennedy, 'The Cultivation of *Hydnocarpus Wightianus* in Nigeria', *Bulletin of Miscellaneous Information* 6 (1936): 341–45.

research and services to enhance proper diagnoses, and foreclose instances in which many patients in the leprosy settlements were not leprosy sufferers, but had some other skin diseases.

Towards achieving these overall objectives, Muir recommended the upgrading of one of the leprosaria into a training and laboratory centre to be headed by a technologist who would be required to undergo a preliminary training course of five or six months' duration in India. There was also the greater need to appoint a leprosy expert to systematise leprosy work in the country, disseminating knowledge and providing advice. Muir particularly stressed the advantages of such an expert in the entire programme of leprosy control, knowing full well the reluctance of the government on this issue since the departure of Mayer in 1931. Muir repeated the association's earlier offer to defray half of the salary of the proposed leprosy expert.

The kernel of the recommendation of Muir's report, especially with regard to the appointment of a leprosy expert for the country, was that there was need for the formulation of an official policy to consolidate and improve upon what had been achieved thus far in leprosy control. The current progress had only further highlighted the extent of the leprosy problem in the country; yet government's response to the recommendations remained lethargic. At any rate, government did not see any need to commit huge sums except to make the barest interventions. Not surprisingly the government refused to contemplate the appointment of a leprosy officer as suggested by Muir; it preferred to begin with the other recommendation of sponsoring one of the leprosarium administrators for laboratory training in India.

Dr T. D. F. Money, the Anglican missionary superintendent of the Oji River leprosarium (Onitsha Province) was proposed for the course in January 1937. On his return in July he received a five-year fellowship on leprosy control for which the belief in official circles was that he would thus serve the purposes of the leprosy expert recommended by Muir, although there was apprehension that as he was not a government appointee he might receive little cooperation from his co-medical missionaries managing the other

leprosaria. 'These missionary leprosy experts', one official expressed, 'do not always see eye to eye'.<sup>50</sup> Money was styled 'Honourary Adviser on Leprosy to the Government' and was placed on an annual honorarium of £52.

BELRA's insistence on the employment of a leprosy expert was a reflection of its view of what it considered government's parsimony with regard to leprosy control. This opinion was shared by not a few contemporary observers. In an article in the *Journal of the Royal African Society* in 1938, C. E. B. Russell opined that 'in no country in the world, so far as we know, is the incidence of leprosy so high as in Nigeria'.<sup>51</sup> Working on the approximate figure of 200,000 given by Muir as the leprosy population of Nigeria and official figures that about 51,000 of these were under treatment in the various leprosaria in the country, Russell concluded that there was much truth in current observations that 'only one out of every 35 to 40 cases is dealt with'. In the circumstances, she concluded, 'it cannot then for a moment be claimed that anything is being done to tackle the problem of leprosy in the Protectorate'.<sup>52</sup> She blamed the government for this state of affairs, deploring the fact that 'out of a revenue of over 6.5 millions only £386,956 was spent on medical work in Nigeria, and of this sum only a very few thousands were allotted to leprosy work'.<sup>53</sup> She urged the government to 'realise the increasing gravity and peril of the situation and decide to allocate, say, at least a million a year to leprosy control for the next ten years'.<sup>54</sup> The sum total of the argument was that government needed to commit more funds for the development of infrastructure (buildings and equipment) and research, and the employment of personnel in the general campaign against leprosy.

Local officials tacitly shared this view. The officials of the native

---

<sup>50</sup>. Minutes from Chief Secretary to the Government to Governor, October 1937, CSO 26/3, File no. 20902/S.1, vol. II, NAI.

<sup>51</sup>. C. E. B. Russell, 'The Leprosy Problem in Nigeria', *Journal of the Royal African Society*, 37 (1938): 66.

<sup>52</sup>. *Ibid.*, 70.

<sup>53</sup>. *Ibid.*.

<sup>54</sup>. *Ibid.*

administrations suggested that government should consider a reduction of their taxes remitted to the central funds to enable them have more funds to spare for leprosy control. The annual commitment of the native administrations was about £16,000. The medical department, which managed the local BELRA, felt too that government commitment was not enough. With government allocation raised from £3,000 to £4,600 in 1937, 'the chairman [of the Executive Committee] was of the opinion that this was not enough in view of the magnitude of the problem; it represented little more than 1% of the expenditure on medical and health services'.<sup>55</sup> 'The committee', it was further reported, 'agreed that Government should be asked to increase expenditure on leprosy gradually, from year to year'.<sup>56</sup>

Even though the governor, Bernard Bourdillon who was now beginning to be sympathetic to BELRA's campaign, was disposed to a substantial increase of government involvement in leprosy control, his senior officials counselled caution.<sup>57</sup> However, the governor became emboldened to take a step forward after his visit to the Oji River and Uzuakoli leprosaria in 1943 where he saw first-hand the organisation and services run by these leprosaria. Impressed with what he saw, 'he got his Director of Medical Services to prepare a scheme for a capital expenditure of £258,000 and an annual expenditure of £40,000 for five years ... from the Colonial Development and Welfare Fund'.<sup>58</sup> In other words government's annual spending was to increase from £5,000 to over £40,000.

For the implementation of the plan, a unit under the medical department called the Leprosy Service was established in 1945 for structural coordination of the leprosy control effort in the country. The service was managed by a board inaugurated in 1950. BELRA

<sup>55</sup>. Minutes of the Fifteenth Meeting of the Executive Committee, 20 July 1937, CSO 26/3, File no., 20902/S.1, vol. I, NAI.

<sup>56</sup>. *Ibid.*

<sup>57</sup>. After his retirement and departure from Nigeria in 1944, he became the Chairman of the Executive Committee of BELRA.

<sup>58</sup>. *BMJ*, 1 (1945): 672.

was divested of its government connections in the new scheme and functioned strictly as a voluntary organisation thereafter. The board of the Leprosy Service included representatives of the principal bodies involved in leprosy work in the country. A substantive leprosy expert was also appointed, initially styled 'Senior Leprosy Officer' and later 'Leprosy Adviser', who also was the secretary of the board. His office was domiciled at the Oji River leprosarium which, with Ossiommo and Uzuakoli, was taken over by the government. These were the largest leprosaria in the country together with the Itu leprosarium. Their patron missions were to continue to be relevant by providing humanitarian and welfare services.

Of no less significance in the leprosy control scheme was the employment by the Leprosy Service of some of the best-known leprologists of the day who staffed its research and laboratory units at Uzuakoli.<sup>59</sup> Foremost was John Lowe who in 1948 pioneered the use of dapsone as an effective oral therapy in the sulphone treatment of leprosy. Following in his wake were T. F. Davey and S.G. Browne. By 1960 when the country attained independence, it was generally acknowledged that the incidence of leprosy was on the decline.<sup>60</sup>

## Conclusion

This article has examined a health issue in Nigeria during the colonial dispensation. The leprosy scare in Britain, which accompanied the high tide of tropical imperial expansion at the end of the nineteenth century, had abated by the 1920s when BELRA began its campaign against leprosy. The disease, therefore, commanded little attention in the formulation of imperial policies

---

<sup>59</sup>. Schram, *A History of the Nigerian Health Services*, 358–60.

<sup>60</sup>. Indeed in the Ogoja area, where the introduction of the new control schemes were relatively belated, Manton notes that 'from 1959 to 1962, the number of segregated patients attached to Ogoja Leprosy Settlement dropped from 2, 144 to 761, while the total number of patients treated also began to show a fall, from 7,482 in 1959 to 5, 294 in 1962, with discharges as cured running at between one and two thousand a year in the early 1960s'. Manton, 'Administering Leprosy Control in Ogoja Province', 320ff.



at the colonial headquarters. Again, by the 1920s colonial rule had been firmly established in British tropical Africa, and so there was more localisation of policy formulation as each dependency emerged as a political entity. Thus, as Michael Worboys has observed, ‘imperial initiatives in medicine, in the sense of empire-wide programmes, were not pursued by the British government or its agencies to any great extent in the years after 1918. These were left to local, regional, and special-interest groups’.<sup>61</sup> Hence, judged from an official point of view, the result of BELRA’s exertions was inversely proportionate to government perceptions of the importance of leprosy in its scale of priorities. But, despite the parsimony of government, much was achieved by its agencies, that is, the native administrations in conjunction with the missionaries and BELRA. It is necessary then to end with a brief consideration of what was achieved.

One feature that certainly emerged by the end of the 1940s was that the country’s Eastern Provinces had the highest incidence and prevalence of leprosy; and it had been suggested that this was a development of the preceding two or three decades following the establishment of British rule, which facilitated greater demographic contacts in this densely populated area. As Davey observed, greater mobility hastened spread of infection: ‘the fear of travel disappeared. Education spread rapidly, but hygiene and standards of living lagged far behind, especially during the years of depression in the 1930s. It is impossible to imagine a situation more likely to encourage the spread of leprosy’.<sup>62</sup> Correspondingly, it was here that leprosy control activities were most extensive. Out of a total of over 51,000 leprosy sufferers under treatment in the country at the close of our period, the Eastern Provinces had some 31,000 patients, thanks to the large leprosaria at Itu, Uzuakoli, and Oji River, which had between them over 19,000 patients.<sup>63</sup> Rapidly

<sup>61</sup> Worboys, ‘The Colonial World as Mission and Mandate’, 218.

<sup>62</sup> T. F. Davey, C. M. Ross, and B. Nicholson, ‘Leprosy: A Changing Situation in Eastern Nigeria’, *BMJ*, 2 (1956): 67, *et passim*.

<sup>63</sup> Thomas McGettrick, ‘Leprosy in Nigeria’, *The Furrow*, 3 (1952): 599–600; cf. R. H. Bland, ‘Nigeria Leprosy Service: Recommendations for a Scheme of Leprosy Control in Nigeria to be Implemented during the Period 1950/55’, Appendix B, 21 March 1949, IjeProf. 1, File no. 780, vol. II, NAI.

declining figures were, however, recorded from the next decade as more successful leprosy control measures were achieved.

Segregation methods in Nigeria, based as they were on self-help in community-type colonies, dovetailed with measures advocated by BELRA.<sup>64</sup> Patients at leprosaria, except pauper patients, paid admission fees into the colonies, but medication and treatment were free. As noted, most patients sustained themselves by farming and others were involved in vocations such as blacksmith work, handcrafts, carpentry and soap making. Lambert, for example, echoes the feelings of the pioneer patients of the Sumaila settlement in 1935: 'Though we are lepers, we built this up. We grow our own millet, guinea corn, beans, sweet potatoes. We grow our own cotton, spin it, weave it and make our own bandages. We make our own pots, knives, scissors and baskets'.<sup>65</sup> As it was the case in Itu, leprosaria patients were engaged and paid for the construction of staff quarters of the medical personnel, administrative buildings and the treatment clinics. These activities, by patients, were considered as occupational therapy, which augured well for their good health. In the larger leprosaria such as Itu and Uzuakoli technical personnel were employed to provide skills and assistance in industrial work. Muir, thus, recommended for the country 'a technical expert who would not be permanently attached to any one settlement, but would spend some months at each settlement in turn and initiate and develop farming, industries, and other vocations'.<sup>66</sup> The importance of such technical personnel in the leprosaria is underscored by Lambert's experience in Sumaila: 'I had had no experience of farming until I came to the colony, so when-ever [sic] I came up against a snag I used to drop a letter to the Nigerian Government Department of Agriculture. They were exceedingly helpful, and enabled me to appear much wiser than I really was to my colonists'.<sup>67</sup>

<sup>64</sup>. On the other hand, sanatorium-type institutions could well be adequate in countries with small leprous populations.

<sup>65</sup>. William Lambert, 'A Leper Colony in Nigeria', *Journal of the Royal African Society*, 36 (1937): 213.

<sup>66</sup>. Muir, *Leprosy in Nigeria*, 14ff.

<sup>67</sup>. Lambert, 'A Leper Colony in Nigeria', 214.

In the more advanced leprosaria of Itu and Uzuakoli, schools were set up as well as law enforcement units and worship centres. In 1931, Itu had six schools for men, women, and children. The children were taught the usual school subjects while the object of running adult schools was principally to enable them to read the Bible in their own language.<sup>68</sup> Lambert also reported that there was a school for children at the pioneer settlement of Sumaila where he taught Hausa, reading, writing and hygiene before the arrival of a native teacher.<sup>69</sup> By the 1940s indeed, schools had become a most important element in the organisation of the various leprosaria, serving as recruitment grounds for the training of auxiliary staff.

From the late 1930s, most leprosaria began to establish satellite settlements and outpatient clinics in their environs in line with Muir's recommendation. By the end of our period there were as many as 125 satellite settlements and 155 outpatient clinics in Southern Nigeria. The north had about 16 satellite settlements and 21 outpatient clinics.<sup>70</sup> This development was best exemplified by the Uzuakoli leprosarium that managed the highest number of settlements and outpatient clinics. Satellite settlements were run by trained ex-patients of the leprosarium under the supervision of the principal medical officer who visited for weekly clinics. These ex-patients were also engaged in conducting house-to-house surveys for cases of leprosy infection. As Leonard Rogers observed in 1946:

that these measures are already proving effective is shown by the fact that during a third house-to-house survey of 7,000 people of one tribe not a single unisolated advanced case was found; but 40 very early ones were detected, which should nearly all clear up with out-patient treatment. With continued frequent surveys, followed by treatment of all discovered early cases, there should be a rapid decline of the disease in such an area.<sup>71</sup>

<sup>68</sup>. Extracts from the Annual Report on Itu Leper Colony, File no. 20902, vol. V, NAI; see also Kalu, 'Beauty for Ashes', 201–207, 213–15.

<sup>69</sup>. Lambert, 'A Leper Colony in Nigeria', 213.

<sup>70</sup>. McGettrick, 'Leprosy in Nigeria', 599.

<sup>71</sup>. *BMJ*, 1 (1948): 828.

Such sanguine hopes were indeed achieved from the 1950s on. The preventive measures of the 1940s, characterised by the house-to-house surveys, gave clearer indications of the extent of the prevalence of leprosy in the country than hitherto.

While a large percentage of the finance was provided by the local administrations, a strong force in the leprosy control programme was the role played by the Christian missions and BELRA. By 1940 all the major leprosaria were connected with Christian missions.<sup>72</sup> They managed the leprosaria and supplied the medical personnel, defraying their salaries in some instances. Although it had become fashionable for these leprosaria to be principally financed and owned by native administrations, some missions retained ownership of their leprosaria. Thus, the Church of Scotland Mission, the Church of the Brethren Mission, and the Roman Catholic Mission retained the control and ownership of their leprosaria at Itu, Garkida, and Ogoja respectively, well beyond the period under consideration. While the management of native administration leprosaria by missions in the northern and Muslim societies of the country was no doubt actuated by humanitarian considerations, it also provided a window of opportunity for religious proselytism or conversion in an area where Christian missionary endeavour had hitherto been officially limited and discouraged. But in another vein, these developments in the north were reflective of a change in perception by the Muslim authorities (emirs) as the leprosarium was viewed by them not as a charitable home as previously conceived but a health and treatment institution. The emirs, Shankar submits, 'translated Islamic ideals of charity into governmental responsibility for medical welfare, demonstrating their modernising impulse in matters of social progress'.<sup>73</sup>

---

<sup>72</sup>. Muir had observed and recommended thus: 'There seems to be general agreement that [leprosaria] are most efficiently and economically established and run by mission doctors, and it would be well to entrust this work...to one of the principal missionary societies in the province'. Muir, *Leprosy in Nigeria*, 5.

<sup>73</sup>. Shankar, 'Medical Missionaries', 47.

Apart from the dissemination of relevant information, the financial support from BELRA went a long way in supporting leprosy work in the country and augmenting the paltry sum provided by the government and native administrations before 1943.<sup>74</sup> It should be pointed out, however, that in the northern part of the country where American missions were active, the American Mission to Lepers (AMTL) played similar roles as the BELRA in supporting the missions in leprosy work.<sup>75</sup>

With regard to the therapeutic treatment of leprosy control, the popular use of the hypodermic chaulmoogra genus was, from the mid-1940s, effectively taken over by synthetic drugs, notably the sulphone derivatives of promine, diasone, promizole, sulphetrone, and dapsone. Dapsone became established as the most effective of the group.<sup>76</sup> This transition from chaulmoogra to sulphone treatment coincided with the period that the Nigerian government committed more funds to leprosy work. The high-quality personnel that was employed as a result, played significant roles in the development of the new drugs with the attendant decrease recorded in the incidence of leprosy in the country from the end of the colonial period. By reducing considerably the duration of treatment therapies and enabling successful outpatient treatment, the new drugs limited the necessity for organised segregation as a control strategy as typified by the chaulmoogra era.

---

<sup>74</sup>. Minutes from Financial Secretary to Chief Secretary to the Government, 5 October 1937, CSO 26/3, File no. 20902/S.1, vol. II, NAI.

<sup>75</sup>. Shankar, 'The Social Dimensions of Christian Leprosy Work among Muslims', 289–91.

<sup>76</sup>. Dapsone (or diamino diphenyl sulphone – DDS) is, in fact, the basic compound or parent substance from which the others are derived.