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A Critique of Leprosy Control Approaches in Northern Nigeria, 1900–1965

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Abstract

The article examines two collaborative approaches to control leprosy in northern Nigeria. In the first approach, the colonial government and the Native Authorities (NA) established leprosy settlements under the supervision of the British Empire Leprosy Relief Association (BELRA). The second approach involved the missions and the NA, which led to the establishment of provincial leprosaria in northern Nigeria. The article uses primary and secondary data which show that the first approach involving BELRA failed to provide the required result until the establishment of leprosaria in provinces of northern Nigeria. The second partnership, which involved the missions and the NA setting up leprosaria, supervised by the colonial administration, provided a holistic approach to controlling and managing the infection, deformity, and stigma related to the disease through the provincial leprosaria.

Keywords: BELRA; colonial government; leprosaria; leprosy control; leprosy settlement; missions; Northern Nigeria

Introduction

Northern Nigeria was called the northern protectorate in 1900 after the British, led by Frederick Lugard, took over the area from the Royal Niger Company. Nigeria came into existence after the amalgamation of the northern and southern protectorates in 1914. Subsequently, the northern part of the region was referred to as northern Nigeria. A substantial part of the area was under the Sokoto caliphate and the Borno empire. The Sokoto caliphate was founded after the jihad of Usman Danfodio in the early nineteenth century, and the Borno empire lasted for many centuries. The region has about 350 ethnic groups, such as the Hausa, Nupe, Fulani, Kanuri, Jukun, Igbira, Tiv, Nupe, and Idoma.¹ After the British invasion and subjugation in the early twentieth century and the creation of provinces,² the area lies from “Niger on the west, to the German frontier on the east, to the Sahara on the north, and Benue and Yorubaland on the south.”³ The region is 281 782 square miles, with the Niger and Benue rivers separating it from southern Nigeria.⁴

Mycobacterium leprae, a microscopic germ closely related to *tuberculosis bacillus*, is considered to be the cause of leprosy.⁵ It affects the patient’s skin,⁶ peripheral nervous system, mucous membranes, eyes, and testes, leading to defects or death.⁷ The disease evolves slowly, with an average incubation period of three years, and is contagious, potentially infecting people of all ages and sexes.⁸ Several clinical signs have been recognised from the early literature in Egypt, India, and Israel; therefore, it is a disease known to humanity for centuries.⁹ Apart from being infectious, the pain, physical deformity, and stigmatisation were social problems experienced by patients. Leprosy hampered social and economic interactions and development in many human societies.

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- 1 Pauline M. Lere, “The Activities of the SIM/SUM Among the Leprosy Patients in Northern Nigeria 1929–1988” (PhD Dissertation, University of Jos, 2005), 6.
 - 2 The northern provinces created by the colonial government in 1904 were Sokoto, Borno, Bauchi, Zaria, Kabba, Kontagoara, Borgu, Gwandu, Kano, Adamawa, Ilorin, Bassa, Nasarawa, Nupe, Katagum, and Muri.
 - 3 Percy Girouard, “The Development of Northern Nigeria,” *Journal of the Royal African Society* 7, no. 28 (1908): 332.
 - 4 Ailon Shiloh, “A Case Study of Disease and Culture in Action: Leprosy Among the Hausa of Northern Nigeria,” *Human Organization* 24, no. 2 (1965): 141.
 - 5 Alfica Seghal, *Deadly Diseases and Epidemics: Leprosy* (Philadelphia: Chelsea House Publishers, 2006), 8.
 - 6 Rod Edmund, *Leprosy and Empire: A Medical and Cultural History* (New York: Cambridge University Press, 2006), 24.
 - 7 “Leprosy in Our Time—Medical and Social Challenges,” The Nippon Foundation, accessed 24 May 2022. <https://www.nippon-foundation.or.jp/en/what/projects/leprosy/work2>.
 - 8 Ernest Muir, “Examination of Contacts in the Control of Leprosy,” *International Journal of Leprosy* 21, no. 2 (1953): 231–34.
 - 9 Tom Frist, *Don’t Treat Me Like I Have Leprosy* (London: ILEP, 2003), 5.

There were varying traditions and opinions on the disease's origin. In Jewish and Japanese customs, in the practices of Hindus, and in ancient Benin it was seen as a form of divine punishment for sin.¹⁰ The Hausa of northern Nigeria had many delusory variations on its causation. It was believed to be either caused by "indiscriminate gluttony," eating the flesh of certain animals such as crocodiles, chameleons, and lizards, or through intercourse with a woman during her menstruation.¹¹ More so, there was a belief that the disease came as a result of a curse from some violent spirits or gods assumed to have been offended by the patient. Generally, it was assumed to have a spiritual connotation among most ethnic groups in northern Nigeria.¹² In some parts of northern Nigeria, leprosy patients were kept in secluded places of their houses or made to live in isolated leprosy settlements in designated sections of the town. This practice was common in areas where the disease was widespread.¹³

Traditional medicine generally has evolved in many cultures in the African setting and has covered many areas. According to Shiloh, "no culture, irrespective of its degree of simplicity or complexity, functions without a range of medical knowledge and beliefs, practices and practitioners."¹⁴ These traditional methods were not haphazardly performed; they cut across several illnesses. Herbal medicine was practiced in various areas of northern Nigeria and played a substantial role in managing diseases, including leprosy.¹⁵ Studies have shown that some Christian missionaries used propaganda against the traditional medical system before establishing Western medical institutions. They criticised some aspects of the African belief, such as sacrifices, traditional immunisation against poisons and evil forces, and all kinds of magic and incantation.¹⁶ Arguably, apart from herbs, some of these vices practiced in the African traditional medical system did not consider certain human sympathies.

Nwude and Ebong claim that Chaulmoogra oil (from *Hydnocarpus* spp.), commonly found in Myanmar and India, dominated the treatment of leprosy disease until the advent of sulphones. Similarly, *Acacia Seyal*, *Del*, *Bauhinia Thoningii* Schum, *Capparis tomentosa*, *Lam* etc., were conventionally used to prevent and control leprosy disease in northern Nigeria.¹⁷ Burning the skin with corrosives like potash and cashew tree juice

10 Brian H. Bennett, David L. Parker, and Mark Robson, "Leprosy: Steps Along the Journey of Eradication," *Public Health Reports* 123, no. 2 (2008): 199.

11 Shiloh, "A Case Study of Disease and Culture in Action," 142.

12 Lere, "The Activities of the SIM/SUM," 82.

13 Lere, 41.

14 Shiloh, "A Case Study of Disease and Culture in Action," 140.

15 Nwankwo Nwude and Omotayo O. Ebong, "Some Plants Used in the Treatment of Leprosy in Africa," *Leprosy Review* 51 (1980): 11–18.

16 Samuel C. Ogubosi, "Christian Missions and the Development of Modern Health Services among the Western Niger-Delta Peoples 1901–1960," in *Readings in Nigerian History and Culture: Essays in Memory of Professor J. A. Atanda*, eds. Dare Oguntomisin and Ajayi S. Ademola (Ibadan: Hope Publications Ltd, 2002), 117.

17 Nwude and Ebong, "Some Plants Used in the Treatment of Leprosy in Africa," 11.

was also common among the Hausa of northern Nigeria. Roots, seeds, bark, and leaves were boiled to be taken orally or for bathing.¹⁸ These demonstrate the efforts to eliminate leprosy through traditional methods in northern Nigeria. Nevertheless, traditional approaches did not completely eradicate the spread of the disease.¹⁹ The reasons were not entirely because of inefficiency, but the number of leprosy patients in northern Nigeria outstretched the traditional system, which could not cater for the increasing infections. Another constraint of the conventional method was its inability to adopt a systematic scheme controlling deformity and stigmatisation.²⁰ Nevertheless, the segregation of patients at a new settlement and the use of herbs proved vital to the traditional control method and cannot be ignored.

Leprosy received much attention in the colonial period, evolving through partnerships. The colonial government partnered with the Native Authorities (NA) of northern Nigeria and, in another phase, the missions and the NA. It is important to mention that before their partnership in leprosy work, the missions and the indigenous authorities (Muslim emirs) in northern Nigeria had a poor relationship since the commencement of colonialism.²¹ Shobana Shankar asserts that in the 1930s the collective leprosy control effort helped in improving the inter-religious relationship between the missions and the Muslim emirs of northern Nigeria. It also became a means of diffusion of Western culture and modernism or cultural transformation.²² Beyond the enhanced relationship and cultural integration, their partnership stimulated a holistic means and method of leprosy control. This article assesses the evolution and implementation of these leprosy control approaches in northern Nigeria. It evaluates the involvement of the British colonial government, the NA, and the missions in the establishment of leper settlements to the provincial leprosaria, which was a holistic approach to tackle the disease, its deformity, and its stigma.

The British Colonial Government's Leprosy Control Efforts in Northern Nigeria, 1900–1935

In 1900, when British colonial rule in northern Nigeria began, there were indications of the prevalence of leprosy in the colony, but the colonial administration left the disease unattended. While there were isolations, most leprosy casualties were severely lepromatous. When it became a significant concern because of the increase in infection, the colonial government set up control mechanisms. Taken from its experience in India,

18 Shiloh, "A Case Study of Disease and Culture in Action," 142.

19 Interview with Adamu Sambo, aged 75, Bayara village, 3 March 2015.

20 Seghal, *Deadly Diseases and Epidemics: Leprosy*, 8.

21 Jan H. Boer, *Christianity and Islam under Colonialism in Northern Nigeria* (Jos: ICS, 1998); Edmund Patrick Thurman Crampton, *Christianity in Northern Nigeria* (Bukuru: ACTS Publication, 1975).

22 Shobana Shankar, "Medical Missionaries and Modernizing Emirs in Colonial Hausaland: Leprosy Control and Native Authority in the 1930s," *The Journal of African History* 8, no. 1 (2007): 45–68.

where it enacted the Leprosy Act of 1898 to curb the spread of the disease,²³ the British colonial government promulgated the 1908 Colonial Ordinance, authorising all provinces in Nigeria to set up colonies for leprosy patients.²⁴ The ordinance also empowered the government to proscribe leprosy patients from participating in any trade or activity that could threaten the public's health. The ordinance was re-enacted in 1916 to underpin the earlier provision for leprosy patients.²⁵

In 1924, the British government established the British Empire Leprosy Relief Association (BELRA) to study leprosy and how it developed and spread throughout the British Empire. Its other responsibilities included educating the British public about the leprosy problem, promoting awareness, and helping leprosy patients with care, treatment, and training to manage the condition. P. T. B Clayton's Toc H was another body that partnered with BELRA to fight leprosy.²⁶ The establishment of the Nigerian branch of BELRA in 1928 was a more thoughtful effort to examine leprosy disease in Nigeria by the colonial administration. In 1929, BELRA supported the Church of the Brethren Mission to set up a leprosy settlement centre at Garkida in Adamawa province. The Christian Mission in Many Lands also established a settlement in Oturpo in Benue province.²⁷

Leprosy disease thrived in northern Nigeria because of climatic conditions, dense population, and traditional and cultural sanitary settings.²⁸ Lere states that "due largely to the climatic difference, there was a lesser number of leprosy patients in the southern part of Nigeria than in the northern part."²⁹ Hence, BELRA's estimate reveals about 95 000 cases of infection in its West African colonies. A subsequent review showed that northern Nigeria alone had more than that figure.³⁰ Oldrieve demonstrates that it was higher than in India, which stood at 0.32 per thousand in the early twentieth century.³¹ According to Dr Ernest Muir, stigma contributed significantly to the increase in infections because patients hid infections until they could no longer be hidden.³² The

23 Sanjiv Kakar, "Medical Developments and Patient Unrest in the Leprosy Asylum, 1860 to 1940," *Social Scientist* 24, no. 4 (1996): 64.

24 T. Ikema, *Rehabilitating the Disabled. A Handbook for Special Education* (London: Hardwork Press, 1948), 2.

25 Government circular No. 45635/35. Memoirs on entry of Missionaries into Emirates. 1932. The National Archives Kaduna (henceforth NAK) as cited in Lere, "The Activities of the SIM/SUM," 154.

26 Andrew B. Macdonald, *In His Name: The Story of a Doctor in Nigeria* (London: Oldborne, 1964), 103.

27 Tunde Oduwobi, "Tackling Leprosy in Colonial Nigeria, 1926–1960," *Journal of the Historical Society of Nigeria* 2 (2013): 192.

28 Charles McConaghy Ross, *Leprosy Control in Northern Nigeria* (Kaduna: NML, 1962), 64; Bauchi Provincial Office No. 1072 Vol. 3. Provincial leper settlements; taking over by the SIM. 1936. NAK.

29 Lere, "The Activities of the SIM/SUM," 91.

30 Shiloh, "A Case Study of Disease and Culture in Action," 141.

31 Oldrieve Frank, "Report on Leprosy problem in Nigeria."

32 Muir, "Examination of Contacts in the Control of Leprosy," 232.

estimated figures above may seem appalling, but it shows how pervasive the illness was in northern Nigeria. But what could cause infection to increase in the region? In this regard, Shiloh provides a fascinating scenario amongst the Hausa of northern Nigeria, stating that leprosy patients lived within the community and family compounds with other people without fear of infection. The reason was that leprosy patients in the Hausa land were not segregated culturally, and the disease “seems to be built into their culture as one of the norms with which they must operate.”³³ Patients, therefore, lived normal lives, and when they became disabled, they resorted to alms-seeking.³⁴ Given that leprosy is contagious, this provided a means for the disease to spread in the region.

In 1930, Dr Ernest Muir, the medical secretary of BELRA, visited Nigeria and made recommendations on leprosy control. He advocated for the establishment of joint leprosy work by the colonial administration and the NA of the northern provinces. Consequently, Provincial Leper Settlements were set up in strategic provinces such as Kano, Katsina, Sokoto, Zaria, and Borno in 1930. Establishing the Provincial Leper Settlements required providing lands for farms for patients with leprosy by the NA³⁵ and supporting means of survival and drugs for leprosy patients by BELRA. In some provinces, such as Bauchi, which aimed to start with the provinces above, there was no provision for plots of land for that purpose or where to site the settlement.³⁶ The settlements were to be staffed by BELRA personnel assisted by Toc H. Toc H had formed a combined committee with BELRA in 1935 and sent out four key workers who had received one-year training from the Livingstone College to start work in northern Nigeria at various leprosy centres in Kano, Katsina, Sokoto, and Maiduguri.³⁷

A few years after the Provincial Leper Settlements began at some places, BELRA staff became discouraged with the work, complaining that it was complicated and challenging and decided to abandon it.³⁸ This development frustrated the colonial government’s anti-leprosy efforts in northern Nigeria. Meanwhile, the disease became pervasive in the region, and the leprosy surveys carried out in the provinces of the north revealed that in Borno there was an incidence of 2.5 per cent, and in Bauchi, it was over 9 per cent. Among the Eggon tribe in the South of Plateau province, around 8 per cent suffered from the disease.³⁹ Sequels to this development and the increasing number of leprosy patients necessitated the colonial government to initiate the provincial leprosaria

33 Shiloh, “A Case Study of Disease and Culture in Action,” 143.

34 Shiloh, 143.

35 Bauchi Province No 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 25, NAK.

36 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

37 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

38 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

39 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

approach.⁴⁰ The new approach engaged the missions in the anti-leprosy project by setting up leprosaria.

Leprosaria and Leprosy Control in Northern Nigeria, 1936–1965

The leprosarium concept was fundamental to northern Nigeria’s leprosy control project. The leprosarium is synonymous with leprosy hospitals, colonies, asylums, and hospitals as progenies of the lazarets of medieval Europe. Despite the traditional efforts, the idea of having a systematic approach to leprosy control was not fully developed in northern Nigeria. Through leprosaria, medical amenities with segregation settlements to safeguard the general public from the disease and meet the leprosy patients’ basic needs were provided.⁴¹ In many instances, leprosaria were built on a large tract of land and isolated from the general population to provide for the leprosy patients’ basic requirements, medical attention, and recreational activities, to reduce the effect of stigma, and assist leprosy patients to reintegrate back into society.⁴² The need to care for the leprosy patients under the concept of the leprosarium is rationalised by Alicia Kaufmann, Mariam Senkenesh, and Jane Neville as follows:

If the patient is not sought and discovered, how should we take care of him? If the patient is not cared for psychologically due to the stigmata and prejudices, how will he react to medical care? Finally, if the cured leprosy patients are not reintegrated into society, has the medical care obtained full effectiveness?⁴³

Leprosaria, therefore, can easily be regarded as all-inclusive leprosy control institutions with wide-ranging services covering a broader framework of leprosy disease and its associated problems for both the patient and society. This idea guided the colonial government in April 1936, through Dr Ernest Muir of BELRA and Dr Walter Johnson, the principal medical officer to northern Nigeria, who requested the Sudan Interior Mission (SIM), the Church Missionary Society (CMS), and the Sudan United Mission (SUM) to be part of a leprosy project with the NA in the region.⁴⁴ The colonial government converted the settlements for leprosy patients to “provincial leprosaria” and obliged the leprosaria to provide village segregation combined with treatment clinics within a radius of 200 miles in the out-stations.⁴⁵ Communities were stimulated to set up a leprosy segregation village at its expense, where leprosy patients were kept under the condition of separation as they underwent treatment.⁴⁶ Located close to the

40 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

41 Frist, *Don’t Treat Me Like I Have Leprosy*, 10.

42 Frist, 11.

43 Alicia Kaufmann, Mariam Senkenesh, and Jane Neville, *The Social Dimension of Leprosy: Training Manual for Health Worker* (London: Ilep Publication, 1982), 7.

44 Bauchi Province No 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 32, NAK.

45 Oduwobi, “Tackling Leprosy in Colonial Nigeria, 1926–1960,” 193.

46 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

segregation villages were clinics meant to offer free medical care to leprosy patients. Severe cases from these villages were referred to the main leprosarium. The leprosaria were to seek out leprosy patients, provide medication and empowerment, care for their psychological needs instigated by prejudice, and reintegrate them into society, thus offering the leprosy patients the opportunity to reunite with their families without fear of discrimination.⁴⁷ The provincial leprosaria were responsible for taking care of the severe cases of leprosy and training the patients in various skills and trades.⁴⁸ The leprosy patients with complications had the physician's care or hospitalisation; in most cases, surgery was performed (Figure 1).⁴⁹



Figure 1: Dr Kuster and Miss M. Shepherd of the SIM performing surgery on a leprosy patient. Source: Bauchi Leprosarium, No. SR-5: 192, 1952–1970, Reports, 19, SIM Archives.

The pertinent thing to contend with in this project was the scheme to collaboratively involve the missions and the NA in establishing and managing leprosaria in northern Nigeria. Undeniably it was a change of approach to control the disease by the colonial administration and the indigenous authorities, partnering with the missions.⁵⁰ Introducing leprosaria in the project was to complement the colonial government's efforts and advance a comprehensive leprosy control approach. Since the project required a colossal capital outlay for the establishment and management of the leprosaria, the process was completed gradually. It developed from Kano, Katsina,

47 Bauchi Province No 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 32, NAK.

48 Provincial Annual Report, 1952, 19.

49 Bauchi Leprosarium, No. SR-5:192, 1952–1973, Miscellaneous, 13, SIM Archives.

50 Interview with Hassan Bichi, aged 65, Kano, 24 April 2015.

Zaria, Borno, Sokoto, Ilorin-Kabba, Bauchi, and Niger.⁵¹ The Bauchi and Niger leprosaria were established in the twilight years of colonialism in Nigeria.

The leprosy control programme was a joint project that involved the missions, the NA, and the medical department of the colonial government,⁵² with each having assigned roles or responsibilities in the building and sustenance of the project. The terms of the agreement provided that the NA would set aside a site with adequate farmland for the inhabitants of the settlement who had leprosy. The NA were required to contribute one-third weekly for every native of their provinces receiving treatment. The total number of leprosy patients for which each NA could accept liability was annually agreed upon between the missionaries and the colonial resident officer when the NA estimates were being considered. The NA would erect a dispensary of permanent construction with furniture and equipment to a reasonable standard and bear the cost of erecting huts to accommodate patients with leprosy. Lastly, they were responsible for supplying or paying for the drugs used to treat leprosy in the camp.⁵³ The colonial government saw the NA as responsible enough to carry out these requirements because it involved them and their subjects.

The missions were to take out a right of occupancy over the part of the site required for the residences of the mission staff and the chapel. They were to use the site for the purpose of a camp and hospital for leprosy patients only and not to proselytise Muslims or preach in public places. According to the terms, proselytising meant an unwelcome visitation from house to house and pressure brought to bear on a person to accept another faith. The missions were prohibited from undertaking forceful proselytisation.⁵⁴ Furthermore, the missions were responsible for the maintenance and upkeep of the leprosaria and for the cost of diets, beddings, clothing, disinfectant, dressing and drugs used to treat concomitant disease, and replacement of equipment, as well as the staff.⁵⁵

As provided by the terms of the agreement, the major players in the new leprosy approach were the missions and the NA. The provincial leprosaria in Kano, Sokoto, and Katsina had all gone ahead, but the Bauchi leprosarium was delayed because of many reasons and concerns. The Bauchi NA claimed that the missions (SIM) could not provide able-bodied and experienced leprosy experts, as suggested by Dr Muir of BELRA. Secondly, the NA held that a shortage of funds would not shortly cause the SIM to relinquish or curtail other minor leprosy work undertaken in the province. On the lack of funds, the Bauchi provincial government argued that the NA did not have

51 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 32, NAK.

52 Bauchi Province No. 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 31, NAK.

53 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 13, NAK.

54 Although the religious provision cannot be argued extensively in this article, it was contentious and practically impossible to stop the mission from carrying out its primary mandate.

55 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 54, NAK.

the financial capacity to support the leprosarium if the establishment became very large.⁵⁶ Contributing one-third weekly for each patient who was a native of the province receiving treatment in the leprosarium was seen as a herculean task by the NA.⁵⁷ Lastly, the NA feared the mission's proselytisation, and it delayed the commencement of the leprosarium for 17 years, from 1936 to 1952, before it was actualised.⁵⁸

Nevertheless, with the new status of "provincial leprosaria," the project was designed to set up more leprosaria in all the provinces of northern Nigeria.⁵⁹ The medical buildings,⁶⁰ houses for all medical and indigenous personnel known as *Anguwan Turawa*,⁶¹ huts for leprosy patients, and a grain storehouse in all the leprosaria were provided across the region.⁶² Funders such as the Broadway Baptist Church's "One Thousand a Month Club" from Indianapolis in the United States of America paid the expenses for these buildings. Similarly, R. M. Dodrill, the American Mission to the Lepers, and the colonial administrations through BELRA and the NA also supported the building and maintenance of the project.⁶³ The leprosaria were electrified, and a stable supply of potable water was provided. Radio telephones were installed to facilitate adequate communication with the provincial government and donors, reducing frequent travel.⁶⁴

Segregated villages and out-patient clinics were established in different places and distributed to satisfy the leprosy patients' medical needs. The leprosaria supervised each segregation village and out-patient clinic.⁶⁵ The missions provided the following leprosy programmes: leprosarium (leprosy hospitals) with a qualified medical doctor in charge, segregated villages with a qualified nurse, and out-patient clinics with a qualified nurse or a qualified, trained staff member in charge.⁶⁶ The colonial government's Leprosy Control Board and the Regional Leprosy Advisory Committees provided ample representation to the missions so that their medical staff trained in leprosy control could guide the pursuance of the policy. Subsequently, the Nigerian Leprosy Service supervised all leprosy work in northern Nigeria.⁶⁷

56 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 54, NAK.

57 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 91, NAK.

58 Interview with Ado Danrimi (aged 45), the Bauchi Emirate Historian, at Kobi Street on 12 December 2015.

59 Secretariate Northern Province No. 17/26516, 1936, Leper settlements, 91, NAK.

60 Provincial Annual Report, 1952, 19.

61 "Anguwan Turawa" is a Hausa language connotation of the European Quarters.

62 Bauchi Leprosarium, No. SR-5: 192, 1952–1970, Reports, 40, SIM Archives.

63 Bauchi Leprosarium, No. SR-5: 192, 1952–1973, Miscellaneous, 23, SIM Archives.

64 Bauchi Leprosarium, No. SR-5: 192, 1952–1969, Resumes, 70, SIM Archives.

65 Albert D. Helser, *The Glory of The Impossible: Demonstrations of Devine Power in the Sudan* (Toronto: Evangelical Publishers, 1940), 31.

66 Yusufu Turaki, *The British Colonial Legacy in Northern Nigeria: A Social Ethical Analysis of the Colonial and Post-Colonial Society and Politics in Nigeria* (Jos: Challenge Press, 1993), 182.

67 Annual Report on the Medical Services for the Year 1949–1950.

The leprosaria were structured into the following sections: the dispensary, physiotherapy section, laboratory, x-ray section, eye section, pharmacy, out-patient department, wards, village settlement, store, and the shoe workshop.⁶⁸ The missions utilised sulphone drugs such as promine, diasone, and dapsone monotherapy with great success.⁶⁹ The development of clofazimine and rifampicin in the second half of the twentieth century also made the treatment of the disease relatively faster.⁷⁰ The drugs offered optimism to leprosy patients, giving them recovery and the ability to return home to their families.⁷¹ These drugs significantly reduced the time spent with leprosy patients in the hospital for treatment.⁷² Regarding dapsone, L. S. Watt stated:

The extraordinary success obtained with Dapsone treatment, especially if the disease is caught in its early stage, has become so well known that lepers or those who suspect they have the disease now come forward voluntarily for treatment and the number of sufferers attending weekly clinics run into thousands.⁷³

All regional and provincial governments organised intermittent training for senior staff and attendants of their leprosaria in administering all new anti-leprosy drugs and managing such cases.⁷⁴ The leprosaria medical staff attended leprosy conferences to equip them with further progress in leprosy control procedures. The training and the information received tremendously facilitated the staff's discharge of their duties (see Figure 2).⁷⁵

68 Lere, "The Activities of the SIM/SUM," 174.

69 Provincial Annual Report, 1957, 20.

70 Frist, *Don't Treat Me Like I Have Leprosy*, 6.

71 Bauchi Province No 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 32, NAK.

72 Bauchi Leprosarium, No. SR-5: 192, 1952–1973, Miscellaneous, 54, SIM Archives.

73 Provincial Annual Reports of 1957, 20.

74 Provincial Annual Reports of 1957, 20.

75 Bauchi Leprosarium, No. SR-5: 192, 1952–1970, Resumes, 36, SIM Archives.



Figure 2: Miss Alma Hixt teaching the indigenes laboratory work in Bauchi Leprosarium. Source: Bauchi Leprosarium, No. SR-5: 192, 1952–1970, Reports, SIM Archives.

In some cases, patients refused to revisit the hospital when early symptoms disappeared.⁷⁶ In this regard, in 1952, Roland H. Bland of the Nigeria Leprosy Service Medical Department revealed that the incidence of leprosy was 80 per thousand in the southern part of Plateau province and an infection rate of about 20 per thousand people in northern Nigeria.⁷⁷ Another survey in the Igabi district of Zaria province in 1953 and 1954 on a population of 5704 indicated that the disease infected 390 people.⁷⁸ Hence, the colonial government developed more policies in 1952, impacting northern Nigeria's leprosy project. There was a proposal to provide at least one central leprosarium for not more than 1000 patients, fully equipped with hospital and laboratory facilities in every province or suitable area. Medical missions were assisted from public funds to establish leprosaria where none existed and to develop existing institutions. These central leprosaria would give priority to the admission and treatment of infective patients and children.⁷⁹ The objective was that the central leprosaria staff would supervise and establish a network of rural control services with segregation villages provided by the local communities for their patients. African workers trained at the leprosaria were to

76 Provincial Annual Reports of 1957.

77 Roland H. Bland, "Leprosy Control in Nigeria," *International Journal of Leprosy* 20, no. 2 (1952): 176.

78 Ross, *Leprosy Control in Northern Nigeria*, 66.

79 Provincial Annual Report, 1952.

operate the rural programmes and services.⁸⁰ These efforts were significant in developing the leprosy control project in northern Nigeria and more impactful in Nigeria's post-independence era.

It is equally important to indicate that government officials paid intermittent official stopovers in their supervisory role to evaluate the leprosarias' performance. They were often taken to see progress in the leprosaria and the patients' wards and residences. Medical doctors from other countries visited to seek more understanding of leprosy and the project's approach to the disease in northern Nigeria. For instance, in 1962, Dr Leiker, the government's leprosy medical officer for Bauchi province, visited the Leprosarium with two doctors from Thailand on a tour of various countries in search of more knowledge on leprosy.⁸¹

The following leprosaria and homes for patients with leprosy were set up from the late 1920s to the post-independence era.

Table 1. Some leprosaria and leprosy settlements in Northern Nigeria and the dates of their establishment⁸²

S/No.	Name	Year	Location
1.	Garkida Leprosy Settlement	1929	Garkida (Adamawa Province)
2.	Oturpo Leprosy Settlement	1929	Oturpo (Benue Province)
3.	Kano Leprosarium (Provincial)	1937	Yadakunya (Kano Province)
4.	Katsina Leprosarium (Provincial)	1937	Babban-Ruga (Katsina Province)
5.	Sokoto Leprosarium (Provincial)	1937	Amanawa (Sokoto Province)
6.	Zaria Leprosarium	1937	Zaria (Zaria Province)
7.	Borno Leprosarium	1937	Molai (Borno Province)
8.	Ilorin Kabba Leper Home	1941	Egbe (Ilorin Province)
9.	Bauchi Leprosarium (Provincial)	1952	Bayara (Bauchi Province)

80 Ogubosi, "Christian Missions," 181.

81 Reuben Luka Shekarau, "The Activities of Sudan Interior Mission in Bayara Area of Bauchi Province, 1952-1972" (MA thesis, Bayero University Kano, 2017), 74.

82 Yusufu Turaki, *An Introduction to the History of SIM/ECWA in Nigeria 1893-1993* (Jos: Challenge Press, 1993), 182-85.

S/No.	Name	Year	Location
10.	Niger Leprosarium (Provincial)	1953	Chanchaga (Niger Province)

The above table does not include the out-stations spread across the region. But there was a significant effort to establish many leprosy control out-stations.

Confronting Deformity and Stigma in the Provincial Leprosaria

Since leprosy is an infectious disease, patients often have deformities, physical disabilities, and experience excommunication. In northern Nigeria, the patient's attitude to the disease was often influenced by widely held traditional beliefs about its causes.⁸³ For instance, the perception that leprosy was associated with one's sin or a curse generally affected patients' attendance at the leprosaria. On the other hand, stigmatisation, as experienced in many places worldwide, unconsciously countered the anti-leprosy effort because some patients refused to be identified with the ailment and its quarantine facilities to avoid public humiliation.⁸⁴ Although isolating infected persons was accepted as a strategy to prevent and control the spread of the disease, it innately exposed the patients to stigma. Muir also discloses that the major problem that impeded leprosy work was "social ostracism," which was also meted against family members.⁸⁵ Stigma and poor awareness of the existence and significance of the facilities meant that only a few patients signed up for treatment at the initial stage. Subsequently, the number increased when they realised what they would gain from availing themselves for treatment. The stipends attached to coming for treatment by the NA made the patients present themselves for medical examination and treatment.⁸⁶ But it is essential to highlight that not all leprosy patients who attended were hospitalised in the leprosaria; those with fewer symptoms were treated and allowed to go.⁸⁷

Most leprosy patients experienced stigmatisation because of the mutilation and crippling deformities the disease caused to their hands, feet, and faces. Relating to the stigma situation in Bayara, where the Bauchi provincial leprosarium was situated, Lere wrote that "the term 'Bayara' for the settlement was a Hausa derogatory description of the 'lepers' settled in this location. The phrase was 'Ba yara sai manya,' meaning: 'no children, only adults,' referring to the patients. This was the stigma associated with the disease and those who were afflicted by it."⁸⁸ Deformities and disfigurements attracted

83 Baktha N. Reddy et al., "Social Aspects of Leprosy: A Case Study in Zaria, Northern Nigeria," *Leprosy Review* 56 (1985): 23–25.

84 John Manton, "Leprosy in Eastern Nigeria and the Social History of Colonial Skin," *Leprosy Review* 82, no. 2 (2011): 124–34. Also see Lere, "The Activities of the SIM/SUM," 40.

85 Muir, "Examination of Contacts in the Control of Leprosy," 232.

86 Shekarau, "The Activities of Sudan Interior Mission," 105.

87 Interview with Adamu Sambo, aged 75, Bayara village, 3 March 2015.

88 Lere, "The Activities of the SIM/SUM," 174.

stigma and can be perceived as a consequence of the poor management of the disease.⁸⁹ Narrating the leprosy deformity situation amongst the Hausa, Shiloh and Shobana demonstrate the plight of leprosy patients with deformity who resorted to street begging.⁹⁰ Iyere corroborates this with the case of Maiduguri by stating:

Leprosy patients with deformities are a common sight in our public places such as supermarkets, roundabouts, squares, churches and mosques. They patronise these places to display their plight to the public and to solicit alms and perhaps to seek an understanding.⁹¹

The World Health Organisation (WHO) leprosy statistical survey conducted in northern Nigeria in the 1960s indicated that about 37.8 per cent of leprosy patients had some disability or deformity of the hands, 30.4 per cent of the feet, and 15 per cent of the face.⁹² This placed the patients in a very intricate socio-economic condition. Indeed, given the number of patients, many of whom were unable to access early treatment, the patients experienced mutilation and stigma. Therefore, the need for the leprosy patients' social, economic, and mental rehabilitation was imperative. Patients' rehabilitation became integral to the idea of the leprosaria.

As noted earlier, leprosy thrives where poverty is predominant; restraining poverty helped the patients' socio-economic and psychological well-being. Shoemaking/repair workshops were established to produce and repair specific foot and hand-fitting wares.⁹³ Interested patients in the region received training in shoemaking and repairs as they underwent treatment at the various leprosaria. Carpentry sessions aimed at the boys and youths were introduced and young ladies were trained in sewing to empower them for life after treatment.⁹⁴ After the training, many trainees set up workshops at the leprosaria premises and in their community markets.⁹⁵ They generated income for themselves, which changed the attitude of their families and friends towards them, increased their self-confidence, brought back their dignity, and reintegrated them into their communities.⁹⁶

89 B. B. Iyere, "Leprosy Deformities: Experience in Molai Leprosy Hospital Maiduguri, Nigeria," *Leprosy Review* 61 (1990): 171–79.

90 Shiloh, "A Case Study of Disease and Culture in Action," 143; Shankar, "Medical Missionaries and Modernizing Emirs," 50.

91 Iyere, "Leprosy Deformities," 172.

92 Martinez V. Dominguez, L. M. Bechelli, and K. M. Patwary, "WHO Surveys of Disabilities in Leprosy in Northern Nigeria (Katsina), Cameroon and Thailand (Khon Kaen)," *International Journal of Leprosy* 34, no. 3 (1968): 244–54.

93 Lere, "The Activities of the SIM/SUM," 174.

94 Bauchi Leprosarium, No. SR-5: 192, 1952–1969, Resumes, 70, SIM Archives.

95 Bauchi Leprosarium, No. SR-5: 192, 1952–1969, Resumes, 70, SIM Archives.

96 Abdullahi Dauda Belel, "A Comparative Study of Income Generation Amongst Leprosy Disabled and Normal Persons Living in a Leprosy Village Settlement" (MPH thesis, Ahmadu Bello University Zaria, 2003), 2.

The leprosaria organised a periodic recreational programme for the patients called “playday” to help patients manage their feelings about the disease. It was always an exciting day for the patients as they participated in various sporting activities and afterwards enjoyed a feast.⁹⁷ The patients were fed three square meals, and items such as blankets and pomade were given to each of them free of charge in the leprosaria. The leprosarias’ prompt attention to medical needs attracted patients from several villages for medical treatment without fear of prejudice.⁹⁸ Likewise, people with leprosy who had undergone treatment in the leprosaria or its out-station and recovered received discharge certificates during a ceremony organised by the leprosaria.⁹⁹

It is essential to note that missions and the NA played a vital role in the history of leprosy control in northern Nigeria due to the institution of leprosaria and the implementation of all government leprosy policies. Their willpower and successes reduced the number of leprosy patients and supported all successful leprosy control and prevention schemes in the region. The joint project involving the missions was more successful than the initial efforts. This is because the missions were committed and focused and had the support of the colonial administration and the native authorities. For the British colonial administration, the involvement of the missions was an effort geared towards the unification and coordination of policies derived from a unified leprosy control service in northern Nigeria.¹⁰⁰ It became an advantage for the medical department of the colonial government to be excitedly involved in leprosy control services indirectly. The initial extension of the leprosy service as an entirely colonial government function was considered unnecessary in this project. In its place, a synergy was achieved between medical missions, local agencies, and the medical department supported by the public coffers in leprosy control.¹⁰¹

Conclusion

This article examined two diverse approaches adopted to control the surge of leprosy in northern Nigeria. These approaches lie between the colonial government, the native authorities of northern Nigeria and the Christian missions. From the onset of colonialism, the colonial government introduced the BELRA branch in Nigeria, responsible for providing and taking care of efforts at controlling the disease in northern Nigeria. The effort of the British colonial administration through BELRA in synergy with the NA to establish leprosy settlements across northern provinces was a consummate failure. This effort did not yield positive results because the disease kept

97 Interview with Ado Danrimi, aged 45, Bauchi, 12 December 2015.

98 Interview with Hassan Bichi, aged 65, Kano, 24 April 2015.

99 Interview with Ado Danrimi, aged 45, the Bauchi Emirate Historian, at Kobi Street on 12 December 2015.

100 Bauchi Province No 1072 Vol. 3, 1936, Provincial Leper Settlements; taking Over by the SIM, 32, NAK.

101 Bland, “Leprosy Control in Nigeria,” 178.

increasing, and not all places had leprosy settlements in the region. Therefore, in 1936, the missions were brought into the fray as a switch in strategy, collaborating with the NA and with the colonial government taking up supervisory roles.

Therefore, the most committed, systematic, and efficient approach to controlling the disease in northern Nigeria was the involvement of the missions and the NA by the colonial government to confront the disease through the concept of leprosia in 1936. The leprosia scheme under the project was a more holistic, practical, and successful approach. It provided treatment, adequate rehabilitation, and management of the psychology of deformity caused by the disease. The delivery of modern medical facilities healed the leprosy patients and reintegrated them into their societies free from stigma, making them more acceptable in their communities. It was feasible due to the commitment of the missions and the NA as well as the support of the colonial administration.

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