

Leprosy in Eastern Nigeria and the social history of colonial skin

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Summary To the historian, the ‘historical’ experience of leprosy control is not simply a backdrop to contemporary patterns or problems in disease control. The control of leprosy has been enacted in different ways in localities, territories and states across the world. The specific clinical, political, and institutional choices made in leprosy control have been highly significant in shaping attitudes and approaches to leprosy. The term stigma has a history of usage, contention and re-definition. Stigma, then, is a product of its intersecting social, economic, and medical contexts. In order to capture the degree to which stigma associated with leprosy has mutated and changed over time, this article concerns itself specifically with the colonial experience of leprosy, with a focus on the formerly leprosy-endemic area of south-eastern Nigeria (known as the Eastern Region, or Eastern Nigeria) in the last quarter century of colonial rule ending in 1960. The article examines *how leprosy was presented*, identifying some of the forms in which ideas of stigma and taint with respect to leprosy were communicated. It goes on to examine *how leprosy was encountered* as a medical problem in Eastern Nigeria, placing leprosy in the context of skin diseases most commonly encountered by colonial medical services. It concludes by demonstrating *how leprosy was understood*, looking briefly at local and biomedical means of identifying and combating these diseases, and the meanings of these diseases in the rapidly changing contexts of mid- and late-colonial rule and the onset of Nigerian Independence in 1960.

Introduction

The historical and contemporary control of leprosy bears institutional, cultural, and socio-economic legacies which draw deeply on the history of leprosy control in the late nineteenth and twentieth centuries. In overview, late-nineteenth century fears of the spread of leprosy, together with a variety of infectious diseases encountered by the agents of growing European empires, brought the disease, its prevalence, questions surrounding its contagion, and its

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relation to poverty to international attention. Much as the spectre of cholera gave rise to a succession of International Sanitary Conferences which related disease control to issues of trade, quarantine and imperial territorial control, and foreshadowed international co-operation in public health in the twentieth century, the history of leprosy control has revisited and refined issues of the transmissibility, classification, diagnosis, and management of leprosy in the light of international debate over its relation to empire and governance, ethnicity, and poverty.

Thus, from the 1867 UK *Report on Leprosy by the Royal College of Physicians*, which foregrounded leprosy as an imperial concern and potential source of alarm, through the series of International Leprosy Congresses beginning with Berlin in 1897, which attempted to consolidate global knowledge, research, policy and legislation on leprosy, the science of leprosy and its control has evolved in close relation to the deeply political and often emotive sensibilities of administrators, policymakers, health workers and patients. The reception of Hansen's work on the leprosy bacillus in the 1870s, of the investigations of Leonard Rogers and others into the utility of chaulmoogra oil in the early years of the twentieth century, and of the developments in sulphone treatment of leprosy in the 1940s and 1950s was shaped by political and economic investments in institutions for leprosy control, and by entrenched fears and impulses which conditioned segregatory responses to leprosy in areas of medium to high prevalence across Asia, Africa and the Americas. This history, then, relates the apparatus of international congresses dating back to the late 1800s, to the persistence of institutional and residential solutions to leprosy-related debility, and to continued discrimination felt by many diagnosed with or bearing the signs of leprosy.

To the historian, this 'historical' experience is not simply a backdrop to contemporary patterns or problems in disease control. Examining the historical record, we can see the emergence of the patterns in the development of leprosy control, in relation to other concerns in medical history, and phases in global and imperial history as sketched out above. The historian seeks to interrogate the relation between these broader patterns abstractly emerging over time, and the grain of local contingency and of specific adaptations to circumstance which both propel the development of technical and political means relating humans to our environment, and shape the human experience of historical change at the level of the polity, the community, the family, the individual, and the body.

The control of leprosy has been enacted in different ways in localities, territories and states across the world. The specific clinical, political, and institutional choices made in response to difficulties and opportunities for both medical workers and communities in leprosy-endemic areas have been highly significant in shaping attitudes and approaches to leprosy. The habits formed around thinking and talking about leprosy over years of engagement with the pathogen, the disease, and its epidemiology have given rise to highly variegated experiences of leprosy across the globe. Though there is a global discourse on leprosy, its terms are not always commensurable across place, and the dialogue does not necessarily reflect either the diversity of human experience of leprosy or the variety of ways in which these experiences are personified or expressed.

As with any other term which seeks to give meaning to a complex social context, *stigma* has a history of usage, contention and re-definition. This sits uneasily alongside its analytical value for the social scientist, the epidemiologist, and the clinician. Stigma, then, is a product of its intersecting contexts, be they local or global, material or intellectual, clinical or social. The local and contingent production of stigma explicates its impact and its persistence, and may well help us to specify strategies for the management of discrimination in relation to leprosy. In other words, this history *matters*. Perhaps more pertinently, if we fail to

interrogate this history, and treat stigma only as a given and measurable category, rather than also as a contingent artefact, it comes to deploy more prescriptive and analytical power than it can usefully bear: in short, it becomes unwieldy and counter-productive. A formulation of stigma which focuses on the measurable and comparative is a key component of public health analyses of prevalence, treatment and rehabilitation in leprosy. But it is not concerned with interrogating the historical roots of variability in social sanction of the leprosy-affected person, and consequently is not an adequately sensitised technique for the prescription of locally relevant approaches to leprosy as a social disorder. To the extent that sensitive programmes of this sort exist, it is through tacit recognition of local historical factors that much of their success may derive, however precisely indices of stigma are derived.

In order to capture the degree to which stigma associated with leprosy has mutated and changed over time, this article concerns itself specifically with the colonial experience of leprosy, with a focus on the formerly leprosy-endemic area of south-eastern Nigeria (known as the Eastern Region, or Eastern Nigeria) in the last quarter century of colonial rule ending in 1960. Stigma, in the historical context of leprosy control and European empire, is a formulation which intimately and continuously partakes of the colonial. As such, it forms part of what we might understand as a social history of colonial skin, of 'skin' understood as an object whose study, analysis, metaphor and lore is conditioned by relations of systemic dependence and inequity, which percolates activities across political, social, economic and medical realms.

The positioning of the body, and by extension its skin, at the centre of the ideological dynamics of colonial medicine has been extensively considered in the South Asian case by David Arnold.¹ Constructive readings of the African body, of the imagined relation between its surface and the character of the African, and of the impact of pigmentation and body morphology on the application of science and medicine in the political circumstances of European empire and racial dominance have substantially added to our understanding of the practice of science and medicine in empire, and of the social meanings and experience of medical intervention in which we can ground a social history of colonial skin.² In the specific Nigerian case under scrutiny, this history emphasises the particular problems of differential diagnosis at a time when diagnostic and classificatory procedures in leprosy were only beginning to assume a relatively fixed form, and had not been disseminated throughout the medical profession in Africa.

On the surface, a strong contrast emerges between historical leprosy control and current means of managing discrimination in relation to diseases with a high social profile (such as HIV/AIDS, MDR-TB and various contagious respiratory diseases, and, in some countries, leprosy). But what I aim to demonstrate is that discrimination itself is historically constituted: it reacts to the particularities not only of disease control and public health administration, but also of economic and social responses and opportunities offered by disease control. We have what is perhaps a visceral shared understanding of what stigma is, and the undesirability of social differentiation and discrimination based on stigma. In the case of leprosy and its control, this article seeks to pick apart the construction of attitudes towards leprosy, and substitute a more nuanced chronology of this process of construction (comprising case discovery, treatment, and rehabilitation) for chronologies reliant on revulsion and redemption which have been central to much of the popular history and rhetorics of leprosy, its stigmatisation, and its control.

The article examines *how leprosy was presented*, looking at a prominent filmic portrayal of colonial leprosy control, identifying some of the forms in which ideas of stigma and taint with respect to leprosy were communicated. It goes on to examine some of the first detailed

studies of the prevalence and presentations of leprosy and of social responses to the disease in Eastern Nigeria, and some of the theories arising from these studies, placing leprosy in the context of skin diseases most commonly encountered by colonial medical services, in other words *how leprosy was encountered*. It concludes by demonstrating *how leprosy was understood*, briefly looking at local and biomedical means of identifying and combating leprosy and other skin diseases, and the meanings of these diseases in the rapidly changing contexts of mid- and late-colonial rule and the onset of Nigerian Independence in 1960. The emphasis throughout is on identifying the historical processes which conferred and carefully tended a sense of leprosy's uniqueness, and the relations of these processes to common and most frequently encountered rhetorics of stigma.

As is well known, the perceived issues surrounding stigmatisation have always shaped the role of terminology in the description of leprosy. It is important to note that while use of the word 'leper' to denote people with leprosy and leprosy patients by direct association with their illness is no longer acceptable in academic and medical discourse, the persistence of this outmoded usage is a matter of record, and the employment of the word 'leper' in this article will always reflect an actual usage in the historical record, consequently reflecting the range of social relations and meanings elicited by historical usage.

PRESENTING LEPROSY AND THE COLONIAL COMPLEX

In terms of the production and consumption of rhetorics of stigma, it is surely significant that major developments in British imperial leprosy control after the foundation of the 'Mission to Lepers' (now The Leprosy Mission International) in 1874, were set in train by Christian missionaries. In Africa, the structure of nineteenth-century interactions between Europeans and Africans, largely urban and trade-based, limited European contact with leprosy sufferers. This fact, combined with leprosy's low mortality rate in comparison with cholera, plague, smallpox, typhus and yellow fever, led to a situation in which 'secular medicine and research showed little interest in the disease and effectively left it to the missions.' This 'accidentally' transformed leprosy into a disease with a different, religious character, as is borne out by the history of leprosy control in Eastern Nigeria.³

This character might give the impression that missionaries imported, created or transformed stigma with regard to leprosy in concert with Biblical interpretations and preoccupations and with translations of medieval leprosy lore. In the popular literature of leprosy control circulating in early- and mid-twentieth century missionary journals for European consumption this often seemed to be the case. But even at best, the Biblical inflections used to represent leprosy to a donor public did no more than to mask missionary preoccupations with a more exigent and diverse set of concerns with the mechanics of leprosy control. Even at its most rhetorically powerful and persuasive, the missionary presentation of leprosy control came more and more to reflect encounters and procedures shaped by host communities as much as by missionaries and colonial administrators.

An important essay in the aesthetic politics of mission, the 1948 feature-length documentary film *Visitation: the Story of the Medical Missionaries of Mary* offers an account of the origins and medical work of an Irish Catholic order of religious Sisters in Ireland and in colonial Nigeria. The film was widely shown in Ireland, the UK (where the Odeon chain undertook its distribution), and the USA. Its striking central section was concerned with the order's leprosy control work in the colonial Nigerian province of Ogoja. This section was key in explicating the particularly complex medical and social labours involved in leprosy control

to the order's potential donor constituency, and the story of its production forms a compelling centrepiece in the accompanying book of the same title written by the film's producer, Andrew Buchanan. The minutiae of the film's presentation of leprosy control, encompassing the diagnostic and therapeutic journey of the individual leprosy sufferer, as well as the model village into which the individual was introduced as patient, builder, inmate, neighbour and Christian, capture many of the dominant formulations of stigmatisation and redemption surrounding leprosy at the dawn of modern dapsone treatment.

The film follows a man given the name of Akong, of strong and healthy appearance, who presents himself to the visiting Sister at a field clinic for examination. Rough patches on his arms and back are noted, which the experience of the Sister enables her to determine warrant a closer examination. With the presentation of a card to Akong, accompanied by admonitory instructions from the Sister directing him to Ogoja Leper Village, his diagnostic journey is set in train. His journey to the Village, 'with his few belongings balanced on his head,' is presented as a journey into hope, though the first scenes of the Village seem to deflate this hope, showing the most severely disfigured sufferers alongside early cases such as Akong.

At this stage, the distinctions between 'contaminated' and 'clean' in the usage of the Leprosy Village, applying both to buildings and individuals, is made clear. Akong walks up to the reception hut, presents his card to a 'clean' African nurse, who motions him to take a seat. Panning across the waiting crowd, the camera focuses on a patient with facial disfigurement and ulcerated limbs, and another with a goitre, noting that leprosy – 'the scourge of Nigeria' – makes of its victims 'a race apart'. The operation of the distinctions epitomised in this peculiar racial categorisation, and in the clean/contaminated dichotomy, permeate the treatment of leprosy control offered in the film, where '[in] this far-away, isolated village, a great human drama is being enacted daily, nightly, not for the benefit of box-office returns, but for the sake of God.'⁴

The level of artifice involved in capturing the images and scenes which comprise the film, evidently a constant battle with light levels on cloudy days, mechanical stress on hot days, and logistical and compositional torment throughout, was magnified by the curious terror of infection which seized the crew and even further exoticised its working practices. Buchanan writes:

'Whilst filming the lepers, the unit was instructed not to touch anything for fear of infection. If reflectors had to be stood around, they should not be touching the ground, for lepers had walked over it. Camera parts should not be put on ledges, tables or elsewhere. Tripod legs would have to stand on an additional surface instead of being placed on the ground.'⁴

This laboured, intricate process, carried out with an 'infinite capacity for taking pains' and 'maximum concentration' led to an arduous filming process, and Buchanan gave reason to doubt that such careful steps were always taken to insulate the filming from the subject.

All the same, the pains taken by the author to communicate these fears emphasised the sense that leprosy, as well as being of intrinsic interest as a medical and institutional problem, embodied a taint which seemed to place its sufferers in a uniquely depraved position in relation to African and European opinion. This was a notion the film attempted both to mitigate and to universalise, showcasing charity in the face of misery, as well as outlining a commitment to up-to-date medical and social care practice as a fount of hope. Thus, while the notion of a stigma attaching to leprosy was foregrounded in the cinematic presentation, particularly with reference to the 'clean'/'contaminated' dichotomy, the patient's passage, by

means of medical examination, to the self-consciously 'normal' life of the leprosy village tempered the severity of the imposed segregating regimen of the leprosy control scheme.

For Akong, a totem of the individual leprosy sufferer in circumstances of empire, the signs visible on the skin were rendered subject to a succession of diagnostic and charitable practices which derived their potency from the specific colonial forms which enabled their evolution and persistence, whether these forms be administrative, investigatory, missionary-charitable, or tutelary-cinematic. As such, segregation and an element of compulsion remain salient features of the control of leprosy depicted in the film, and the sign on the skin of the individual is normalised as conditioning the social and administrative response to the prevalence of leprosy.

Already in the early 1950s, the personification of the leprosy sufferer as 'leper', an isolate but not an individual, an invitation to alms resounding through the depictions of leprosy in missionary rhetoric, was beginning to diminish in appeal. This approach manifested its inconsistencies in the more personalised vignettes presented by the Medical Superintendent and Settlement teacher at Ogoja in the late 1950s. In these accounts, the patient Hyacinth, baptised and married in the Catholic Church prior to coming down with leprosy, provided 'an example of Christian resignation such as one would find in Catholic Ireland where everyone's lot, no matter how hard, is God's will,'⁵ and 'Dr.' Effiong, an experienced dresser at Ogoja Leprosy Settlement, was, at his death, 'carried away in the dead of night by his people', leaving the author musing 'Why? There is no use guessing. The answer to that question will never be known. "It is the custom of our people . . ." Maybe.'⁶

In many ways, however, these tales are residua of an approach to leprosy no longer embraced even by those who wrote such pieces. The naked appeal to a shared sense of Catholicism among Irish and Nigerian, embodied in the author's reflections on Hyacinth's story, itself explains the appeal of the rhetoric of 'the leper' to missionary publicists. But interspersed with such articles in the pages of the monthly periodical of the Medical Missionaries of Mary, and slowly outnumbering them, were a succession of increasingly sophisticated attempts to present the curability of leprosy and the modernity of missionary health care to a European audience in the late 1950s, a time when European society was itself subject to immense social and intellectual upheaval.

ENCOUNTERING LEPROSY

T.F. (Frank) Davey, subsequently editor of *Leprosy Review* and clinical leprologist at Dichpalli Leprosy Hospital, India, was a Methodist missionary and perhaps the foremost epidemiologist of leprosy working in colonial Nigeria. He was based at the leprosy settlement at Uzuakoli, Owerri Province, Nigeria between 1937 and 1958, and undertook some of the earliest comprehensive local leprosy surveys in colonial Owerri Province. In his 21 years in Nigeria, he witnessed, and was in part responsible for, the development of an extensive missionary- and government-funded leprosy control programme across Eastern Nigeria. His documentation of the missionary and medical encounter with leprosy was both rich and carefully considered, and elicits many of the complications which tempered and modified the stigmatisation of leprosy in the region.

In his research for a 1938 doctoral thesis, based on surveys carried out in the Abua, Item and Etiti Ama areas of Owerri Province, a short distance from Uzuakoli, Davey detected an already wide range of reactions to, and accommodations with leprosy on a village-to-village basis. Together with this direct survey material, Davey collated a range of impressions regarding local concepts of leprosy which he used to propose a control model along the lines

suggested by Ernest Muir, a prominent leprologist with substantial Indian experience, following his 1936 visit to Nigeria.

What is perhaps most striking about these local concepts is the non-existence of indigenous strictures in many areas of Eastern Nigeria by the 1930s, and the puzzling laxity of implementation of such strictures in those areas where leprosy seems to have been feared. Davey writes as follows:

“In the Calabar Province [where the famous Itu leprosarium, founded in 1926, was based], the attitude of the people to leprosy is one of apathy. Lepers are not feared, contact with them is permitted, and there is in consequence a high incidence of leprosy”.

‘Among the Ibos of the Owerri Province, some diversity of thought exists. There is a widespread belief in a supernatural origin to leprosy. The disease is believed to be a curse from the spirit world, and in some villages the curse is believed to be of so dreadful a nature that the leper is denied that right of resurrection into the spirit world which other mortals share. . .’

‘Among such people, leprosy control should be a simple matter, yet it is surprising to find a considerable amount of apathy among the people in spite of their religious beliefs regarding the disease. Thus at both Item and Etiti Ama, lepers were found in the village, though it was apparent that well established cases of leprosy were regarded with abhorrence. . .’⁷

In later years, Davey had occasion to comment on the exceptionally deep decline in the incidence of leprosy in Eastern Nigeria, surmising that a number of factors, such as the possibly epidemic profile of leprosy in the region, the increasing incidence of tuberculosis, the improved standards of living across the region after 1945, and considerable investment in leprosy control, impacted variably on this decline.⁸ Davey’s remarks on the potentially recent vintage of leprosy on such a large scale could equally account for either apathy or panic, action or resignation. Further, they point to the non-existence of a generalisable pre-colonial stigmatising approach to leprosy across the region. Such a formulation, it would seem, emerged from the unique circumstances of a rapid missionary-led response to a perceived urgent medical crisis in what was, after all, only recently colonised territory.

A significant complication in the diagnosis and recognition of leprosy as an individual, community, and public health problem in colonial Nigeria was the widespread prevalence of skin diseases relating to rural living conditions and poverty. Most significant among these was yaws, which was endemic in rural Eastern Nigeria. Even at an early stage in his investigations, Davey concluded that the distinctions between leprosy, yaws, and other sources of markings and lesions on the skin were not always sufficiently appreciated by Nigerian patients.

“In early cases however, particularly of the neural variety, the patient may present a problem of considerable difficulty which can only be solved after careful local and general examination. The patient is of little assistance. On survey, macules are described as being produced by yaws, burn scars or insect bites.”⁷

After 20 years of work in Nigeria, he still noted the impact of yaws on the perception of leprosy, which was perhaps more a feature of Eastern Nigerian circumstances than anywhere

else. He noted that “. . .during the past 20 years [to 1957] massive yaws infection in a dense rural population has been accompanied by an outbreak of leprosy of unusual magnitude.”⁹ The combination of poor facilities and avenues for the treatment of yaws, and common occurrence of leprosy led to a clinical situation in which “. . .a variety of skin manifestations may be encountered in which the one disease can simulate the other very closely.”⁹ This visual link was corroborated by the experience of extensive yaws surveys carried out in Eastern Nigeria under the auspices of WHO and UNICEF from 1953, which uncovered substantial numbers of leprosy sufferers among those surveyed and treated for yaws.¹⁰

Further, Davey was of the opinion that leprosy in Eastern Nigeria was a relatively mild disease, noting that “. . .[t]he patient with mutilations and serious complications is generally rare [even] though severe and moderately severe infections have been more than sufficient to fill settlements to capacity.”⁸ In this respect, the shaky foundations of strictures against leprosy patients in easily legible skin lesions seem ever more closely correlated with the evolving dynamics of colonial medicine. This impression tallies with features of local approaches to leprosy control which will be discussed further in the next section of this article.

UNDERSTANDING LEPROSY AND COLONIAL SKIN

Linking leprosy and its control to a grand project of American imperial citizenship in the Philippines, Warwick Anderson describes the island leprosy colony of Culion in terms of its projected impact on the behaviour and political citizenship of the Philippine archipelago at large. In his reading, Culion is a forge for a new form of citizenship, a ‘biological and civic transformism in which the contaminated became hygienic, and “savages” might become social citizens.’¹¹ The evident seriousness with which this bio-political project is pursued is clear from the high proportion – approaching one third – of the colonial health budget which was devoted to Culion and to leprosy after 1922, attributed by Filipino nationalists to an American obsession with leprosy and its relation to civilisation.¹¹

Eastern Nigeria was not subject to the same type of elaborate public health governance as was the Philippines; there were far more onerous problems faced by the British colonial regime in governing Nigeria. In the East, in particular, proponents of the indirect rule model favoured by British colonial administrators in much of Africa (by which tax-raising and legal functions of the colonial state would be carried out, cheaply, by existing indigenous authorities) failed to identify the appropriate political agents among Igbo and Ibibio communities which made up a large proportion of the region’s population. This led to a sweeping crisis of legitimacy which culminated in the 1929 Women’s War and the subsequent dismantling and remodelling of the apparatus of the colonial state.¹² Prior to World War Two, the colonial state in Eastern Nigeria focused mostly on public order, agricultural production and revenue-gathering, leaving much of the medical work and all leprosy control in the hands of Christian missionaries. This remained the case until 1945, with the founding of the government-run Nigeria Leprosy Service, which took control of two of the region’s best-developed leprosy centres, the Methodist-run Uzuakoli centre and the Anglican-run Oji River Settlement.

Even then, the predominant model for leprosy control in Eastern Nigeria was not to be that pursued at the agro-industrial residential leprosy township at Itu. While this was the region’s most prominent leprosy control institution, it was not representative (though it has often been taken to be so). In deference to the intensely local political sensibilities of the

majority of the region's inhabitants, leprosy control proceeded on the basis of Ernest Muir's recommendations that provincial centres form a nucleus of a substantial clan-based network of segregation villages.¹³ This greatly fragmented the administration of leprosy control and the formulation of policy; it also increased local stakes in the successful outcome of any process of tendering for or providing leprosy services.

Throughout the East, the problematic issue regarding any gathering of leprosy sufferers continued to be that of cost. Administrators and missionaries alike attempted to evolve policies which would share the burden of leprosy control costs with Native Authorities and their successor local councils. While leprosy control did not begin in earnest until the founding of the Church of Scotland Itu Leprosy Settlement in 1926, the Great Depression of the 1930s saw local authorities repeatedly pressed to make financial provision for leprosy patients either at Itu, which was very expensive to maintain, or at locally agreed sites. Even while expenditure was still very low, the wisdom of forcing hard-pressed local authorities to make provision for leprosy control was often queried, with one District Officer pronouncing in 1940 that "...this country is being stampeded into a disproportionate expenditure on leprosy" given the persistence and prevalence of other serious diseases, and that "...[p]erhaps what these other diseases lack is the propaganda drive of the Anti-Leprosy Associations."¹⁴

A prevalence of leprosy variously estimated at between 5% and 12% of the population in parts of the region seemed to justify such expenditure.^{8,14} The availability of funding for large-scale leprosy control work after 1945, provided by missionary organisations, the British Empire Leprosy Relief Association (BELRA, later LEPROA), and the Nigerian colonial government, anchored leprosy control institutions as key infrastructural and developmental resources across much of rural Eastern Nigeria – at the height of leprosy control in the region, in the early 1950s, leprosy accounted for a similar proportion of the Colonial Development and Welfare budget as all other medical services.¹⁵ This represented a high rate of capital investment in leprosy research and outreach, but the emphasis was less on re-making Nigerians than on stemming what appeared to many to be a genuine public health crisis.

In enacting leprosy control, land, labour and compulsion regarding the issue of case isolation were important issues to be brought to the attention of local leadership. All three remained problematic throughout the heyday of colonial leprosy control. Petitions to colonial administrators continually bemoaned the porosity of leprosy settlements, disputes over land and access to markets and water resources for leprosy patients, and, increasingly and perhaps paradoxically, the failure of authorities to site appropriate local leprosy institutions in particular areas.¹⁶ This latter indicated a perception that the leprosy control institution was becoming an important indicator of development, over and above its public health purposes. For their part, missionaries and administrators complained of the difficulty of securing access to labour required to build and contain leprosy segregation villages, despite the apparent good will of local authorities.

In this novel local politics of leprosy control, the leprosy patient was effectively to be transformed not into a citizen, as in Anderson's formulation, but into a community resource. Within the financial wherewithal of a colonial administration under tight fiduciary control, and local authorities whose ability to meet the demands of public health and other welfare related works varied greatly with prevailing global economic conditions, the leprosy patient maintained a highly ambiguous position. Given the scale of leprosy as a public health issue, a serious effort to sunder links between the majority of leprosy-affected individuals and society at large was never undertaken. This was a source of continual anxiety to missionary and

government leprosy workers and policy makers, underlining the sense of crisis which percolated colonial visions of leprosy in Eastern Nigeria.

The skin of the leprosy patient, only partially distinguished from that of the rural inhabitant of Eastern Nigeria was, at the moment of its passage into the institutional purview of the leprosy control institution, briefly subjected to methodical medical and welfare processes. Such patients were only ever a small proportion of the larger leprosy-affected population, whose health needs were increasingly addressed at outpatient level, their disease '[involving] little physical discomfort and no disability.'⁸ And even these patients entered into what was broadly recognised as a porous institution, maintaining relations with families whose financial burden the institution helped to relieve, perhaps to the benefit of emotional ties. The operation of stigma was, it would seem, less in relation to the skin and person of the leprosy patient (however difficult the individual circumstances of patients whose ability to work was limited), than to the colonial production of this 'skin' as subject of missionary and government representations of leprosy, of anxieties over colonial capacity to control the disease, and its perceived impact on the colonial territory at large.

Conclusion

"Like all identities, those rooted in leprosy underwent profound transformation in colonial and postcolonial Mali."¹⁷ So writes Eric Silla in his portrayal of Malian reactions to leprosy control in the twentieth century. The same could clearly be said for colonial and post-colonial Eastern Nigeria. In this rapidly shifting political, social and economic scene, the impact of techniques of isolation and segregation on Africans, both as leprosy patients and as individuals concerned with what came to be defined as the problem of leprosy, was mitigated by tendencies to accommodate welfare and medical development goals within new understandings of Nigerian political structures. This process continually problematised the representation of leprosy control, as issues surrounding leprosy became entangled with local and regional resource politics and priorities.

While it is fair to say that the Christianity of the missionaries in Eastern Nigeria was a crucial determinant of the shape and outcomes of the medical encounter between Europeans and Africans, it is much more difficult to describe the ways in which the encounter was so determined. The slippage surrounding 'leprosy' and 'stigma' as conceptual and physical constructs exacerbate these difficulties, and at the same time demand a more rigorous approach to their resolution. Any attempt to deal with the range of issues raised must take into account the structure of medical and religious practice, and the various ways in which individuals and groups sought to negotiate their relations with one another. Though the effects of this politics of mission were most keenly felt at a local level, events in Eastern Nigeria were impinged on by broader issues in ecclesiastical, cultural and medical politics.

Underlying the stylised representation of medical rectitude and of the grateful reception of the leprosy village programme visible in the film and literary propaganda of Catholic missionary organisations was an intensely contested vision of the local significance of leprosy control. This vision was fought out and elaborated at the level of petitions, representations, and council debates, as well as over control of access to labour, land, and markets. More than simply signifying the frayed edges of a tightly marshalled control and propaganda exercise, African notions of the scope and responsibilities of leprosy control schemes did much to shape the constraints under which these schemes operated. These notions were articulated not

only in direct representations to missionaries and doctors, but also visible in the tensions between mission and government.

The filmic elaboration of the typical encounter with the leprosy sufferer, the construction of stylised biographies of leprosy patients in villages, and the ideal subjectivities which these representations propounded, present the idea of a 'leper' shorn of the particularities which animated both the day-to-day administration of leprosy villages, and the programme for the management and development of leprosy services province-wide. In reality, the conceptual and practical borders of the leprosy village were in need of continual reinforcement, amid the traffic in private patients and outpatients, defaulters, the discharge of community responsibilities, farming, markets and commerce.

The permeability of these borders was strategically refocused through the lens of stigma, one of the primary ordering concepts in western biomedical thought about leprosy. This concept, at the interface between the history of Christian religious and social thought, and the social project implicit in scientific biomedicine, held tremendous functional appeal in the articulation of a Christian discourse on colonial development. It also acted to reinforce the armoury with which the further reaches of missionary leprosy control were policed. The intellectual heritage and heuristic value of the ideas surrounding stigma were continually called into question when confronted with the variety of local thought and practice regarding leprosy. Significantly, though, the explanatory power of notions of stigma regarding leprosy, continually reinforced through missionary propaganda, and operationalised in distinctions between varieties of skin lesion to which the rural population of Eastern Nigeria were thought susceptible, helped conserve the power of large-scale institutional approaches to leprosy control: in this way, persisting forms in institutional leprosy care received substantial intellectual underpinning from powerful ideas on the social position of the leprosy sufferer.

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