The Roman Catholic Mission and Leprosy Control in Colonial Ogoja Province, Nigeria, 1936-1960

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Preface

This thesis explores the part played by the Roman Catholic Mission in the evolution of the language and stakes of political action in late colonial Ogoja Province, Nigeria, in the particular guise of its role as provider of leprosy control services under the auspices of the Nigerian colonial government. In doing so, it makes use of previously unexamined archival material in Nigeria, and contrasts the emergent portrait of Catholic missionary welfare provision in Ogoja with mainstream scholarly accounts of Nigerian development politics, the history of mission in Africa, and the history of leprosy, its treatment, and control. Given the low profile of the histories of Catholic mission, of leprosy, and of Ogoja in the scholarly community at large, the clarity of the contrast I draw out in the course of the thesis will be aided by the following terminological remarks.

The term 'Roman Catholic', as opposed to Catholic, is used throughout to accord with the naming practice used in official colonial and Nigerian government documentation. The terms 'Irish Catholic' and 'Nigerian Catholic' refer to Roman Catholic in Irish and Nigerian contexts. Further, the term 'RCM Ogoja leprosy scheme' is used as an umbrella descriptor for what is referred to, in various contexts over the sixteen years of its existence I examine here, as the Ogoja Leper Settlement or Scheme, the Northern Ogoja Leprosy Scheme, and the Ogoja Leprosy Centre.

For terminological convenience, the terms Ogoja and Ogoja area will refer to the area bounded by the colonial Ogoja Province, though in the context of Roman Catholic Mission (RCM) leprosy control activities this designation will contract to indicate the northern three divisions of Ogoja, Obudu, and Abakaliki, along with Ikom Division. Reference to northern Ogoja, in the archival record usually indicated in the context of leprosy control, will be taken to encompass the northern three divisions, and to include Ikom from 1953, when the RCM undertook to provide leprosy services there. Explicit use of the terms Ogoja Division and Ogoja town will be made in the text with reference to these more specific geographical entities. Where appropriate, whether with reference to constitutional change or

administrative convenience over the forty-one years covered by the study, changes in terminology used to designate certain areas will be adopted in the text and duly explicated.

The use of the word 'leper' to denote leprosy sufferers and patients by direct association with their illness is no longer acceptable in academic and medical discourse. The perceived issues surrounding stigmatisation have always shaped the role of terminology in the description of leprosy, and increasing optimism regarding its treatment coincided with the vote to abandon use of the word 'leper' in technical communication, and to encourage its abandonment in popular usage, at the 5th International Leprosy Congress held in Havana, Cuba in 1948.[1] The persistence of this outmoded usage is a matter of record, and the employment of the word 'leper' in this thesis will always reflect an actual usage in the historical record, consequently reflecting the range of social relations and meanings elicited by historical usage.

1 International Leprosy Congress, *Memoria del V Congreso Internacional de la Lepra: celebrado en La Habana, Cuba del 3 al 11 de Abril de 1948 / organizado por el Gobierno de la República de Cuba con la colaboración de la Asociación Internacional de la Lepra*, (Havana, 1949), p. 95.

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My own interest in the broader field of Irish Catholic mission in Africa stems in part from a childhood familiarity with missionary and charitable publicity, both as disseminated in schools, and through family social connections. Neither source of information was uncommon in mid- to late-twentieth century Ireland, but I must credit the sustaining of my own particular interest to the friendship of Fr. Michael Doheny, and, later, to the encouragement of his brother, Fr. Kevin Doheny. This thesis owes much to their memory.

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The staff of the Wellcome Library for the History and Understanding of Medicine, the British Library Main Collection and Map Library, and the Public Record Office in London, The National Library in Dublin, and Rhodes House, the Bodleian Library, the Radcliffe Science Library, faculty libraries in Modern History, Theology, and Social Studies, and the libraries at Nuffield College, and at the Wellcome Unit for the History of Medicine, all in

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I hope, in this thesis, to do justice to the blend of healthy scepticism, and respect for individuals and their beliefs, fostered in me by the Manton and Campion families. My grandparents lived through a century of rapid change, and I have always puzzled over the world in which they, and later, my parents' generation, grew up. It is to them, John and Margaret Manton, and Thomas and Delia Campion, that I owe my curiosity and its fruits. My parents, Tom and Breda, my siblings, Anne-Marie, Paul, Deirdre, and Margaret, their partners, and my nephew Samir, have always stood by me, and have offered me every opportunity over the years. I hope that this thesis serves as a token of my gratitude to them in return.

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Table of Contents

Preface ... ***1***

Acknowledgements ... ***3***

Maps – Tables – Figures/Photos ... ***9***

Abbreviations ... ***10***

Glossary ... ***12***

Chapter One - *Introduction* ... ***14***

Understanding late colonial political space ... 18

Medicine and interpretation in historiographies of colonialism ... 24

Methodological remarks ... 29

Thesis summary ... 35

Chapter Two - *Broadening contexts for a critical history of leprosy control* ... ***40***

Assessing 'leprosy' in medicine and rhetoric ... 40

Irish Catholicism and the character of Catholic mission in Africa ... 46

The historiography of Ogoja in its colonial and Nigerian context ... 56

i) population, language, trade, and migration in the Ogoja hinterland ... 56

ii) Ogoja - colonial commentary ... 66

iii) Colonial Nigeria and the history of administration in Ogoja ... 75

Chapter Three - *Exploring leprosy in the context of colonial control: Ogoja Province to 1945* ... ***81***

Leprosy in pre-colonial Ogoja and early colonial Nigeria ... 81

Colonial administration and leprosy in Ogoja – 1934 ... 85

The Roman Catholic Mission and leprosy in Ogoja – 1936-1937 ... 89

Leprosy and local politics - 1938-1939 ... 97

Seeds of change at the RCM in Ogoja, and in Nigerian policy on leprosy control, 1939-1945 ... 99

Wartime debates on Nigerian leprosy control in Britain ... 114

Framing proposals for RCM leprosy control - Ogoja Province, 1945 ... 120

1945 – leprosy control in transition ... 125

Chapter Four - *Leprosy control and the development of Catholic and mission identity in Ogoja* ... ***128***

Constructing an exemplary daily life ... 129

A Sister's work on a medical mission ... 132

Managing a fledgling leprosy control service ... 132

A convent in the context of mission ... 138

Emerging from behind the scenes: the making of Visitation ... 141

The greatest sacrifice: becoming a “Nigerian” mission ... 154

Chapter Five - *Creating and managing institutional spaces for leprosy control* ... ***159***

Practical issues in missionary leprosy control – i) local ... 161

Practical issues in missionary leprosy control – ii) administrative 170
Chapter Six - *Catholic medical enterprise in Ogoja, 1945-1953*.......... ***185***
Leprosy control, maternity care and general medicine in Ogoja Province.......... 186
Subject to inspection: early difficulties with medical administration.......... 191
Chemotherapy and clinical trials in leprosy: situating Ogoja in a global research context.......... 197
Chapter Seven - *Leprosy control, mission, and decolonisation in Ogoja Province, 1953-1960*..... ***214***
Statistical introduction.......... 214
"The leper": an abstract African.......... 220
The RCM and the emerging Nigerian political establishment.......... 226
Global public health and local leprosy services.......... 230
Reframing religion and medicine.......... 239
Conclusion.......... ***244***
Constructing a field of enquiry for the history of leprosy control.......... 246
(i) Medical therapies and the development of leprosy services.......... 246
(ii) The politics of administering leprosy control.......... 247
(iii) African responses to missionary leprosy control.......... 248
(iv) Catholicism and leprosy control.......... 250
Bibliography.......... ***253***

Maps – Tables – Figures/Photos

Number	Title	Page
Map 1:	Location of Ogoja Province in southern Nigeria	18
Map 2:	Population density in Eastern Nigeria (1953 Census)	57
Map 3:	Ethnic diversity in Ogoja and surrounding areas	58
Map 4:	Ekoi/Ejagham-speaking communities in Ogoja Province	59
Map 5:	Relative prevalence of leprosy in Nigeria, 1932	83
Map 6:	Leprosy settlements in Nigeria, 1937	85
Map 7:	RCM-administered leprosy control area (including Ikom from 1951)	127
Map 8:	Incidence of trypanosomiasis in Nigeria, 1946-49	187
Map 9:	Hospitals in Nigeria – location, management, and size, 1955	189
Table 1:	Estimates – Eastern Nigeria development expenditure	80
Table 2:	Patient statistics - RCM leprosy control areas, Ogoja Province	215
Table 3:	Ogoja Province population figures from 1953 Census	217
Table 4:	Patient admissions/discharges: Ogoja LS (comprising Obudu)	217
Table 5:	Leprosy control statistics for Nigeria: Eastern Region	218
Table 6:	RCM institutions and centres for treatment of leprosy, Ogoja	218
Table 7:	Data from RCM sacred returns for Ogoja Prefecture/Diocese	219
Figure 1:	Cover from memoirs of a founder of the RCM in Ogoja, 1921	89
Figure 2:	The ideal leprosy settlement	94
Figure 3:	Film still – Akong's arrival in Ogoja	149
Figure 4:	Film still – taken from *before* diagnosis	150
Figure 5:	Film still – shaping future missionary strategies	153
Figure 6:	Commemorating Sr. Matthew Carey in *The Medical Missionary of Mary*	156
Figure 7:	MMM stall for 1953 UK Missionary Exhibition	223
Figure 8:	From *The Medical Missionary of Mary*, June 1960	225

Abbreviations

BELRA – British Empire Leprosy Relief Association

CSM – Church of Scotland Mission - in order to avoid confusion, the Anglican 'Church Missionary Society' is referred to by its full title, unless abbreviated to CMS in a quoted passage

CD&W – Colonial Welfare and Development - referring to the 1940 Act of this name

DADPS, DDS, dapsone – diaminodiphenylsulphone, a treatment for leprosy

DO – Divisional or District Officer - generally not used due to potential for confusion

ITS – Initial Treatment Survey – 1950s UNICEF Yaws Survey programme

Kiltegan – St. Patrick's Missionary Society - known after the location of Irish headquarters

LS – Leprosy Settlement

m. leprae/tuberculosis – mycobacterium – the organism causing leprosy/tuberculosis

MB/PB – multibacillary/paucibacillary – modern diagnostic terms for varieties of leprosy

MMM – Medical Missionary/Missionaries of Mary

MMS – Methodist Missionary Society

NA – Native Administration

NAE – Nigeria National Archives, Enugu

NCNC - National Council of Nigeria and the Cameroons

NGO – Non-Governmental Organisation

NLS – Nigeria Leprosy Service

RCM – Roman Catholic Mission

TB/TBL – Tuberculosis/Tuberculosis and Leprosy

UN – United Nations

UNICEF – United Nations International Children's Emergency Fund

VAD – Volunteer Aid Detachment (World War One)

WHO – World Health Organisation

Glossary

Scientific terms are explained, where relevant, in the text. The following are terms or distinctions with a specific significance in religious or missionary contexts.

Apostolate – 'A society or sodality of persons having as their object the propagation of a method or rule of faith, life, or conduct.' *Oxford English Dictionary*, 2nd ed., (20 vols., 1989), 1, 558.

Almoner – Social worker in a hospital. Thus 'almonary' – referring to the work of an almoner.

Canon Law - 'Canon law is the body of laws and regulations made by or adopted by ecclesiastical authority, for the government of the Christian organisation and its members'. From *Catholic Encyclopedia*, (1910). See http://www.newadvent.org/cathen/09056a.htm . It should be pointed out that prior to the Second Vatican Council and the subsequent ecumenical mandate, the word 'Christian' in Catholic parlance commonly related to Catholic issues alone.

Catechism – instruction in the elements of religion. Thus, *catechist, catechetics*.

Congregation/Order – both terms refer to a community bound by a common rule; *order* has a more technical application to the rule or discipline involved.

Magnificat - The hymn of the Virgin Mary in Luke 1:46-55

Monstrance - a receptacle for visual presentation and veneration of the consecrated host, usually among the most valuable and highly ornamental artefacts in any Catholic Church or parish.

Month's mind - an element of Irish Catholic funeral observance, consisting of a Mass celebrated one month after the passing of the deceased, often at the family house or graveside.

Nun/Sister – The distinction, according to the letter of Canon Law, centres on solemnity of

the vows taken, and papal enclosure in monasteries. The term *Nun* refers to a woman religious in an enclosed order; the Medical Missionaries of Mary are referred to as *Sisters*.

Religious – This term refers to professed members of the Catholic Church, be they priests, nuns or brothers; thus, the term 'women religious' distinguishes nuns and religious sisters from lay women.

Sacred returns – returns of diocesan/institutional activity compiled for the Vatican

Vicariate/Prefecture/Diocese – A vicariate is an ecclesiastical office administered on behalf of the Bishop of a larger diocese; the recognition of a prefecture has, in modern times, signalled the increasing independence of a missionary territory from a greater diocese, and the prefect apostolic is conferred as a titular bishop; when a prefecture becomes a diocese, the titular bishop becomes bishop of that diocese, as happened in Ogoja in 1955.

Visitation – This represents the Visitation of the Blessed Virgin Mary to her cousin, Elizabeth, before the birth of Jesus. It is an important feast for the Medical Missionaries of Mary, and was incorporated in the title of the 1948 documentary about their missionary work in Ireland and Nigeria. It is also defined in the *Catholic Encyclopedia,* (1910), under the heading 'Canonical Visitation', (see http://www.newadvent.org/cathen/15479a.htm) as 'The act of an ecclesiastical superior who in the discharge of his [sic] office visits persons or places with a view of maintaining faith and discipline, and of correcting abuses by the application of proper remedies.'

Chapter One - Introduction

> Níl an galar tógálach, nó an-tógálach ar a laghad. Ach mar sin féin baineadh an-phreab asam nuair a bhogas i measc na lobhar agus gur caitheas lámh a leagan ar chuid acu agus breith ar lámh orthu. Ar ndóigh leanann créachta agus míchumaí gránna an galar. Caithfidh mé a admháil gur tháinig iarracht de mhasmas orm. (Ó Fiannachta, 1982, p. 63)[1]

> The Evangelisation of the Ogoja area began in 1921 with the arrival of Fathers Douvry and James Mellet [sic] on May 15, the eve of Pentecost. It continued for long from the Calabar axis and reached maturity in 1955 with the erection of Ogoja as a Diocese, and Bishop T. McGettrick, its first ordinary. As early as 1937 St Thomas' Training College was built. Thereafter there were numerous schools, primary and secondary. The Catholic Church is noted here for her tremendous work in health care especially the care of lepers - leprosy being prevalent in the area. Leper villages and settlements were built where patients received care from the missionaries.(Nwosu, 1982, p. 49)[2]

This thesis examines the role of the Roman Catholic Mission (RCM) in leprosy control in colonial Ogoja Province, south-eastern Nigeria, between 1936, when the mission was first invited to co-ordinate leprosy work, and 1960, when Nigeria achieved national independence and ceased to be administered as part of the British Empire. My analysis focuses on the RCM Ogoja leprosy scheme, founded in 1945 after almost a decade of failed efforts and war-induced delay, under the auspices of St. Patrick's Missionary Society (Kiltegan) and administered by the Medical Missionaries of Mary (MMM), two recently founded and predominantly Irish Catholic missionary societies. This scheme offers a useful template for the examination of the role of mission in the construction of colonial administration, the local and international ramifications of decolonisation, and the evolution of ideologies and genealogies of development and global public health.

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1 P Ó Fiannachta, *Ón bhFuacht go dtí an Teas*, (Maynooth: An Sagart, 1982), p. 63. This passage, describing the author's visit in early 1982 to the leprosy hospital and village run by the Medical Missionaries of Mary at Abakaliki, Ogoja Province, translates as 'The disease is not contagious, or at least not very contagious. But in spite of this I got quite a start when I went amidst the lepers and had to touch some of them and shake their hands. Terrible wounds and disabilities result from the disease. I must admit a fit of nausea overcame me.' Incidentally, the Irish language words for leprosy and leper, *lobhra* and *lobhar*, share a root with the word for rotten and decaying, *lobhadh/lofa*. Translations from Irish are mine.

2 V.A. Nwosu, 'The growth of the Catholic Church in Onitsha Ecclesiastical Province', in A.O. Makosi and G.J.O. Ojo (eds.), *The History of the Catholic Church in Nigeria*, (Lagos: Macmillan Nigeria, 1982), p. 49. J.P. Jordan, *Bishop Shanahan of Southern Nigeria*, (Dublin, 1949), ch. 24 narrates the founding of the Catholic Mission in Ogoja by Frs. Douvry and Mellett, en route to evangelise among the Tiv to the north of Ogoja Province. On failing in their original mission to the Tiv, the two men retreated to Ogoja.

On the Nigerian periphery, from both infrastructural and ethnic perspectives, colonial Ogoja Province also seems marginal to scholarly considerations of Nigeria as a whole, and for much of the twentieth century, its demographic and linguistic profile remained largely unfathomed. However, by considering an Irish-run, Catholic welfare project conducted under the auspices of a British colonial regime, the history of leprosy control in Ogoja Province offers parallels and comparisons which raise novel problematics of imperialism and decolonisation, adding texture to existing accounts of mid-twentieth century African history. In this sense, it is precisely its apparent marginality that endows the features and outlines of this enterprise with such resonance.

The quotations with which this chapter opens, by an Irish and a Nigerian Catholic priest respectively, are excerpted from texts describing and celebrating the first papal visit to Nigeria by Pope John Paul II in 1982. They draw attention to specific features of the European Catholic engagement with people and places in the Ogoja area, and inadvertently highlight problematic issues in traditional depictions of leprosy work. Hinting at a wide network of institutions, which aspired to complete coverage of leprosy sufferers in local communities, and reflecting some of the distaste adhering to popular conceptions of leprosy, the accounts of the Roman Catholic Mission Ogoja leprosy scheme given by Nwosu and Ó Fiannachta encapsulate both the complexity and the peculiarity of the enterprise being described. The Irish, and Catholic dimensions of leprosy control in Ogoja are also distinctively foregrounded in these representations, and the notion of sacrifice, requiring 'tremendous' efforts to overcome the psychic barriers popularly associated with leprosy, runs as a current throughout, as it commonly has in missionary literature on leprosy.[3]

From the vantage point of commentators on Church and mission, leprosy control emerges as a practice apart, conducted in a space apart, and practised by people with a vocation apart - the producer of a significant film on the work of Irish medical missionaries going so far as to cast the leprosy sufferer as one of 'a race apart'.[4] The sense of apartness alternately contrasts

[3] Z. Gussow, *Leprosy, Racism, and Public Health : Social Policy in Chronic Disease Control*, (Boulder, 1989), ch. 10.
[4] A. Buchanan, *Visitation: the Film Story of the Medical Missionaries of Mary*, (Drogheda, 1948), p. 103.

with, and bolsters, missionary notions of ministry to leprosy. Within hagiographical rhetoric, the mission to leprosy exhibits an internally cohesive self-sufficiency, a keen sense of its own isolation, and a sense of institutional and ideological holism.[5] This holism, inflected with religious significance, adheres to the individual mission station in spite of its diverse links to local populations and administrations and the plurality of interfaces which structure the medical encounter with patients and their communities.

Thus, in published missionary accounts of leprosy control, the fundraising apparatus, the regulatory framework, the biomedical context, the extent and permanence of institutional structures, the title to lands, and the capacity for outreach of any individual leprosy control enterprise, remain subservient to the opportunity for spiritual exaltation through the suffering and sacrifice occasioned by the missionary encounter with leprosy.[6] The complexities of the demand for and reception of leprosy services, the consequent ramifications for the relevant institutions, and the intricacies of leprosy and leprosy work as a social construction, are collapsed into twinned rhetorics of physical recovery and spiritual salvation. In order to conduct a reflective exploration of missionary enterprise, the complex politics of space which result, and the ideological deformities thereof, must be carefully disentangled.

Leprosy stands in unique relationship to the history of the western biomedical encounter with European imperialism. Irene Brightmer suggests that the profile of the European response to the prevalence of leprosy in a variety of colonial settings led to situations in which leprosy was constructed as 'different'[7] in character to other diseases. Any consideration of colonial and postcolonial approaches to leprosy must therefore be prefaced by an understanding of the circumstances in which leprosy came to be thought of as 'different', and of the impact this construction had on interactions between Europeans and colonial populations.

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[5] P. Myers, *Uplifted Hands: the Story of Leprosy*, (Tralee, 1951) provides numerous examples of heroic ministry which illustrate the rhetorical traits outlined.

[6] Alongside Myers (1951), and Buchanan (1948), works such as P. Thompson, *Mister Leprosy*, (Dunton Green, 1980), A. MacDonald, *No More "Afar Off"*, (London, n.d. [1964]), and E. Mackerchar, *The Romance of Leprosy*, (London, n.d. [1949]) extract a redemptive message from the anecdotally sketched outlines of leprosy control.

[7] M.I. Brightmer, 'The Spatial Pattern of Leprosy in the Cross River Region of Nigeria', (Ph.D., Liverpool University, 1994), p. 65.

With this in mind, I aim to show that the Roman Catholic Mission was involved in shaping the colonial administrative space known as Ogoja Province in crucial and decisive ways, complementary to those of the colonial administration and its successor Nigerian government but distinct in form from them. The Roman Catholic Mission operationalised a priest-people distinction within the mission which shared many characteristics with Catholic clergy-lay relations in Ireland, and institutionalised relations of spiritual and pastoral guidance which it is tempting to read as inculcating dependence.

Furthermore, the hierarchical clerical forms of Catholic mission, as distinct from the various Protestant missions more broadly prevalent in British colonies, had a decisive impact on the development of leprosy control in Ogoja. More specifically, this development is predicated on the intricacies of the relationship between Catholic Canon Law[8] and the practice of medicine, and on the position of religious women in Catholic mission. These must be explicated in order to grasp some of the crucial issues in the chronology of Catholic missionary healthcare.

The Roman Catholic Mission interpreted and grounded evolving norms of colonial and post-colonial governance in a geographical area which otherwise seemed to have little stake in the emerging late-colonial Nigerian political accommodation. Leprosy control played a key strategic role in grounding post-1945 development politics in Ogoja Province, given the local pre-eminence of the RCM from the point of view of colonial welfare provision. Separating the construction of colonial space from the evolution of medical knowledge, in the course of the rest of this introduction I consider the intellectual contexts informing and underpinning the formulation of my thesis.

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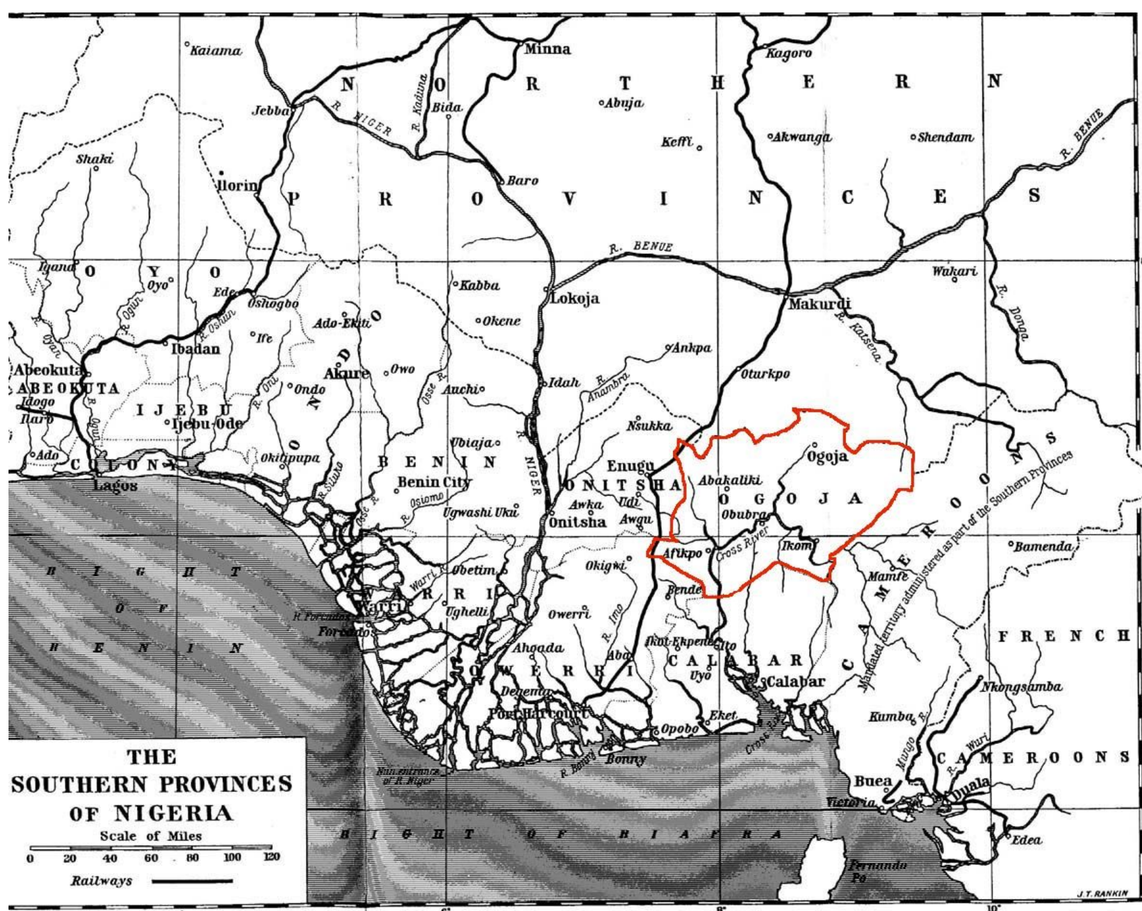
[8] See Glossary.

Understanding late colonial political space



Map 1: Location of Ogoja Province [outlined in red] in southern Nigeria[9]

The sequence of political reorganisations in late-colonial Nigeria continually buffeted and destabilised the available fora for representing local needs and grievances, in the variety of ways these were constructed across the culturally diverse Ogoja area. Despite regular wholesale change at the level of the colonial administration, the practices and policies of the Catholic mission provided a source of continuity which led it to be implicated in significant, if not always straightforwardly tangible, ways in the governance of Ogoja's communities and in the reshaping of political, medical, social and economic strategies employed. The mapping of a variety of colonial and missionary understandings of local community, ethnicity and organisation onto a structure for the delivery of leprosy control and ancillary medical

9 M. Perham, *Native Administration in Southern Nigeria*, (Oxford, 1937), inside back cover. The outline of Ogoja is my own.

services had a decisive influence on the relations between communities in Ogoja, and in the political accommodation between Ogoja Province and Nigeria as a whole. In transforming scant and insufficient knowledge of local issues into norms for governance, the Roman Catholic Mission and colonial administration collaborated in the construction of the terms of engagement between Ogoja, interpreted and presented as periphery, and the variety of geographic and discursive centres with which it related. These varied from regional, national, and colonial administrative centres in Enugu, Lagos, and London, through spiritual centres in Calabar, Ireland and Rome, and centres of medical research, knowledge, and expertise in Uzuakoli, Yaba, London, Dublin and the United States, to global centres for the co-ordination of public health work in Geneva and New York.

The understanding of space which underpins metaphors of mapping and scale in this thesis is informed by recent trends in historical geography. In attempting to engage as much as possible with the specificities of locality as they emerge in the archival record, discerning variations in patterns of disease, acceptance or rejection of leprosy sufferers, siting and timing of leprosy control activities, I take inspiration the close grained technique employed by William Smyth in his analysis of post-Cromwellian transformations in settlement patterns in two counties of Ireland.[10] This study of political reorganisation attempts to separate and then re-collate local instances of displacement and accommodation in order to investigate the coherence of national and nationalist historical narratives of conquest. Marilyn Silverman and P.H. Gulliver note the partial experience of group history by any subdivision of this group[11] whether defined by class, profession, religion, ethnicity, gender or geographical boundary, and explicitly relate this to the problematising of national chronologies, while Vincent Tucker points out the need to situate the local with regard to global political economies in seeking to understand its relevance and context.[12]

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[10] W.J. Smyth, 'Making the documents of conquest speak: the transformation of property, society, and settlement in seventeenth-century Counties Tipperary and Kilkenny', in Silverman and Gulliver, (eds.), *Approaching the Past: Historical Anthropology Through Irish Case Studies*, (New York: Columbia University Press, 1992), pp. 236-90.

[11] M. Silverman and P.H. Gulliver, 'Historical anthropology and the ethnographic tradition: a personal, historical and intellectual account', in Silverman and Gulliver, (eds.), (1992), pp. 9-11.

[12] V. Tucker, 'Localism in Irish ethnography', in *Current Anthropology*, 35, 2 (1994), pp. 200-02.

In Ogoja, Catholic lay and missionary religious personnel shared conceptions of what should rightfully form the outlines of an appropriate medical politics in the context of an evolving Nigerian health service. The basic conceptions of a Catholic medical politics were developed and reiterated in a number of styles and fora across late colonial Nigeria. One of the crucial tasks of my thesis will be to demonstrate how the interplay of spiritual, bureaucratic-administrative, and medical-clinical factors structured the outcomes, not only of an internal mission politics, but also of the elaboration of forms of provincial life and political engagement across much of colonial Ogoja Province. Consequently, I offer foundations for a fundamental redescription of political process at the local and regional level in colonial Nigeria, bridging the type of rich account of local practice and the variety of intimate colonial encounter unearthed and propounded by social constructivist and discourse theoretical approaches to African history, and the state-level accounts of nationalist politics and patterns of decolonisation which have formed the basis of common understandings of African societies in their engagement with the world at large.

One of the central components of this redescription is an understanding of the spatial dimension of multiple identities attributed to social actors in more thoroughgoing constructivist accounts. The notion that such an understanding might be useful and relevant draws on themes in the geography of health care, summarised by John Mohan in his commentary on the approach of a group of British medical geographers to '[comprehending] the importance of spatial arrangements of services in shaping social lives'.[13] Mohan's account adds texture to the postulated link between institutional arrangements and hegemonic forms of discourse, explaining:

> Philo... consequently argues that we need to move away from narrow conceptions of autonomous 'logics of spatial organisation' to a view of geographies of institutions produced by 'creative locational acts' whose origins lie 'deep within a matted web of prejudices, intuitions, convictions, assumed "facts", hopes and fears'... As Taylor... notes, administrative boundaries are not simply spatial structures; they connote and signify issues of power, legitimacy and accountability.[14]

The articulation of the local with the global in order to properly explicate the political

[13] J.F. Mohan, 'Explaining geographies of health care: a critique' in *Health and Place*, 4, 2 (1998), p. 121.
[14] Mohan (1998), p. 121.

dimensions and significance of local enterprises is of crucial importance in the elaboration of this thesis. The understandings afforded by outlined approaches from historical geography shift the burden of historical explanation from the national to the local and international, from a focus on the state as social fact to an emphasis on the allegiances which created and replicated its power at a local level. This enables the scholar to determine the relations between a set of interactions in a specific location – in this case, between missionaries, administrators, communities in Ogoja and leprosy patients – and national and international trends in the politics of development.

While this thesis does not present an historical geography of pre-colonial and colonial Ogoja Province, nor provide what would commonly be understood as an ethnography of either a larger Ogoja 'community', a leprosy institution, or an international missionary enterprise, it does seek to describe and foreground a set of processes which have far-reaching implications in a variety of locations and contexts across Ogoja. In this respect, the framework offered by Axel Harneit-Sievers, in his examination of the significance of community-state relations in defining the Igbo 'Town',[15] helps in understanding the task which this thesis seeks to accomplish. Harneit-Sievers distinguishes between 'creating community from outside', and 'creating community from within', noting the reconfiguration of local alliances, the creation of Christian understandings of social cohesion and competition, the construction of ethnicity as an epiphenomenon of colonial epistemology, and Igbo reconceptualisations of migration and belonging, authority and clan-town relations.

Though the market for publishing local histories is not as vigorous in northern Cross River State as in Igbo areas of eastern Nigeria, there is ample documentation enabling the reconstruction of a similar set of processes of community creation in late colonial Ogoja Province. The archival record provides little of the micro-level detail necessary to reconstruct the spatial dynamics of power in Ogoja, and how the exercise of power divided among administrator, missionary, appointed native authorities, and local personages. As a result, my

[15] A. Harneit-Sievers, 'Making the Igbo 'Town': local communities and the state in southeastern Nigeria since the late 19th century', (Habilitationsschrift, University of Hannover, 2001). I thank Dr. Harneit-Sievers for permitting me to read and refer to his work.

focus could be said to be predominantly on the creation of community from outside. Though the pattern of politics could be described as 'colonial', the manner in which colonial Ogoja was created results from a complex and curious interplay of forces, which themselves lumber uneasily under this designation. The shape of the Nigerian state at the time of independence owes much to iterative attempts to collapse local and regional specificities under a continually contracting set of administrative rubrics and techniques,[16] but the manner in which this process is enacted in particular locales and within designated borders seems to have been extremely varied.

Prominent tendencies within Nigerian historiography have often acted to obscure distinctions between varieties of expatriate, types of colonial enterprise and denominational distinctions among missionaries, interpreting colonial action according to national teleologies. Political exigencies in contemporary Nigeria seem also to privilege, and indeed to demand, enquiries which relate competition for resources to the construction of ethnically-mandated claims to stakes in Nigeria's government structures.[17] This thesis is not intended to examine the creation of an ethnicity or a series of ethnicities in contention with one another, but to demonstrate how a particular form of political space evolved, in which the means of negotiating and securing access to resources was transformed as a result of colonial interactions not necessarily designed with this end in mind. It also contends that missionaries played a vital role in these transformations in a variety of locales.

In the post-1945 era, global organisational networks yoked together missionary foundations and institutions, leprosy charities and research organisations such as BELRA, post-1945 NGOs such as Oxfam, and global health and welfare agencies such as WHO and UNICEF. I argue that this process, alongside allegiances based on support for research and treatment, underpinned a new missionary strategy, which invigorated and stabilised the organisations involved, and was distinct from earlier missionary emphases on amassing souls. This

[16] For south-eastern Nigeria, this balancing act can be traced quite clearly through A.E. Afigbo, *The Warrant Chiefs: Indirect Rule in Southeastern Nigeria 1891-1929*, (London, 1972), and J.S. Coleman, *Nigeria: Background to Nationalism*, (Berkeley, 1971).

[17] For instance T. Falola, *Nigeria in the Twentieth Century*, (Durham, NC, 2002), betrays a strong weighting towards instrumental analyses of Nigeria's past in the light of recent political troubles.

contrasts with the accounts provided by scholars such as Andrew Walls, who detects a highpoint in western Christian mission, from which inevitable decline set in, in 1910,[18] Michael Worboys, who claims that the British Empire Leprosy Relief Association (BELRA) declined in importance after 1940,[19] and Zachary Gussow, who relates the increased involvement of global public health agencies to a secularisation in the administration of leprosy control.[20]

In short, the resulting technocratic turn in mission did not obviate its impact: indeed the growing implication of missionaries in state structures gave a different character to late-colonial mission worthy of detailed study in its own right. Teleologies of decline in mission, part and parcel with narratives of the Africanisation of Christianity, form a crucial plank of the growing literature in mission studies of which Walls' work is emblematic. Considerations of the peculiarities of Irish, and Catholic mission[21] draw attention to alternative histories of the missionary engagement with Africa, alternate chronologies of its rise, and novel accounts of its legacy.

As Stephen Howe inadvertently demonstrates in his work on Ireland and Empire,[22] debate on the controversies surrounding Ireland's claim to colonial and post-colonial status has led to the refinement of analytical techniques for the study of structures of governance as colonial artefacts. Howe's critique focuses on the 'national' contexts of these debates, and how the detritus of theory corrupts the clarity of analysis of Ireland's past and present political problems. However, in so thoroughly problematising the colonial, without entirely rejecting its analytical saliency, Howe offers an opportunity to effect a retreat from nationalising historiographies in order to recompose common understandings of the workings of the state in both its narrower regional and local and broader transnational, international and global

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[18] A.F. Walls, *The Cross-cultural Process in Christian History: Studies in the Transition and Appropriation of Faith*, (Edinburgh, 2002), p. 53.

[19] M. Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', in *Osiris* 15 (Series 2) (2001), pp. 217-18.

[20] Gussow (1989), ch. 10.

[21] E.M. Hogan, *The Irish Missionary Movement: A Historical Survey, 1830-1980*, (Dublin, 1990); J. McGlade, *The Missions: Africa and the Orient*, (Dublin, 1967); and 'The modern missionary movement', in D. Fennell, ed., *The Changing Face of Catholic Ireland*, (London, 1968).

[22] S. Howe, *Ireland and Empire: Colonial Legacies in Irish History and Culture*, (Oxford, 2000).

contexts. While he expresses caution regarding the tendency of a stress on complexity to result in indeterminacy,[23] Howe's focus on answering questions about the 'nation' distracts him from the rewards promised by more finely-grained analysis.

In effect, my analysis excavates a distinct set of relations between African states and development-oriented organisations, and hopes to offer a more convincing account of the politics of social provision in Africa than analyses which focus more generally on inherent weaknesses of the failing African state and its traduced political inheritance.[24] While recognising the complicity between mission and development (both colonial and post-colonial) theorised by Firoze Manji and Carl O'Coill,[25] and examined in the context of Irish mission by Richard Quinn and Robert Carroll,[26] this thesis attempts to trace the negotiated evolution of strategies of development, and the implication of spiritual and missionary colonial norms in these strategies, with the hope of eliciting a more nuanced analysis of emerging welfare and development politics in mid-twentieth century Africa.

Medicine and interpretation in historiographies of colonialism

With regard to the role of medicine in the construction of identities and political stakes in colonial and post-colonial African polities, there is a ready, engaged and diverse interpretative historiography which facilitates the exploration of this theme. The significance of symbols and images, translations, and interacting medical knowledges in elaborating a linguistic politics of colonial engagement is amply documented by Nancy Rose Hunt. Hunt turns progressivist paradigms of the history of biomedicine in Africa on their heads through an exposition of the interpretative validity of African reflections on ongoing encounters with

[23] Howe (2000), p. 197, commenting on Ruane and Todd's multi-factorial analysis of conflict in Northern Ireland.

[24] See C. Young, *The African Colonial State in Comparative Perspective*, (New Haven, 1994), for a relatively generous critique from what can be a scabrous literature on 'kleptocracy' and state piracy.

[25] F. Manji and C. O'Coill, 'The missionary position: NGOs and development in Africa', in *International Affairs*, 78, 3 (2002), pp. 567-83, especially the section headed 'From missionaries of empire to missionaries of development'.

[26] R.F. Quinn, and R. Carroll, *The Missionary Factor in Irish Aid Overseas*, (Dublin, 1980)

missionaries, colonial administrators and unfamiliar medical technologies and ideologies.[27] However, her contention that we treat 'missionary texts as inscribed forms of oral tradition'[28] short-circuits the important scientific, clinical, theological and spiritual contexts and histories which inform the construction of these texts, with their elaborate international and institutional components and communicative channels, and recapitulates an all-too-familiar fallacy in Africanist historiography of collapsing the varieties of European enterprise into simple facets of a process of contact and translation. Thus while local social contexts are depicted in detail, the ramifications of contact and translation on the evolution beyond African borders of European and western medical and development ideologies are left unexamined, an imbalance which may paradoxically reinforce the marginality of African concerns in histories whose reach is rightly global.

A sense of the contested meanings accorded to topography and space is neatly conveyed by Osaak Olumwullah in his description of 'why the AbaNyole [of western Kenya] thought that they suffered from [certain exotic] diseases during colonialism'.[29] In a vignette which poignantly inverts local conceptions of landscape, Olumwullah poses a missionary on a hilltop with important local spiritual significance, from where a view of the neat and ordered mission is contrasted with the haunting shadows of a pagan past, which had dissipated and no longer imbued the African landscape. Local relations to landscape are characterised as constituting an obsolete 'past', and are compared to the 'present' of planned mission enterprise, envisioned from above, both literally and figuratively, by the observing and intervening missionary.[30]

More broadly, though, Olumwullah's account of biomedicine's impact on Africans mirrors the lacunae in Hunt's presentation, providing an insufficient distinction between African employees of colonial enterprises, Christians, African converts, and other less 'traditional'

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[27] N.R. Hunt, *A Colonial Lexicon of Birth Ritual, Medicalization, and Mobility in the Congo*, (Durham, NC: Duke, 1999), especially introduction, chs. 1 and 2 for an understanding of Congolese interpretations of the role and significance of early missionaries and their actions.

[28] Hunt (1999), p. 23.

[29] O. Olumwullah, *Dis-ease in the Colonial State: Medicine, Society and Social Change among the AbaNyole of Western Kenya*, (Westport, CT, 2002), p. 19.

[30] Olumwullah (2002), pp. 103-04.

members of African communities, where Hunt leaves the European dimension of biomedical and missionary communities in Africa essentially unexamined.[31] At the same time, Olumwullah usefully complements Hunt's account of colonial mediations and translations with a pointed unmasking of the reshaped and re-evaluated relations with space and landscape heedlessly foisted on rural African communities by the machinery of European imperialism.

Megan Vaughan outlines how a nuanced depiction of power relations can be elicited from the process of creating colonial subjectivities in a variety of biomedical encounters and settings. Examining contexts of psychiatric institutions, pre-World War Two leprosy settlements, disease eradication campaigns, and missionary-run dispensaries,[32] among others, Vaughan's account is sensitive to the diversity of institutional framework and ideological background informing European medical enterprise in Africa. At the same time, the broader focus on the pathologised African at the level of the individual and of society, necessary to the critical function of Vaughan's argument on the historically and geographically contingent nature of biomedical discourse, precludes the detailed examination of government, missionary, local, and international interactions in the evolution of a single institutional context. However, in its emphasis on the need to account for the salience of colonial and state power in shaping African lives and livelihoods, in the wake of the inadequacies of previous accounts of colonialism as either accidental or conspiratorial exposed by Anne Phillips,[33] Vaughan's work is crucial to the lexicon of translation, inversion, revalorisation and pathology offered in the literature on the African encounter with biomedicine, a lexicon which will form a vital component of my analysis.

The intimate micro-political analysis facilitated by these interpretative approaches to medicine in colonialism helps to subvert some of the dominant models of the role of

[31] While Hunt's work is evidence of a more even-handed assessment of European missionary work in Africa, following writers such as J.D.Y. Peel and Terence Ranger in providing a less judgemental, and less strident account of mission than its historic supporters and detractors, its purpose is not to excavate the European cultural, intellectual and political contexts of the missionaries she writes about.

[32] M. Vaughan, *Curing Their Ills: Colonial Power and African Illness*, (Cambridge, 1991), chs. 2-5.

[33] A. Phillips, *The Enigma of Colonialism: British Policy in West Africa*, (London, 1989), introduction. Phillips notes the shortcomings of descriptions of colonialism as *ad hoc*, and of dependency theory, in accounting for the relation between colonialism and metropolitan capitalism.

medicine in both colonial and global political economies. Much of the work which attempts to encompass local and global does so by means of focus on a particular disease, on a particular medical organisation, or on a particular scientific discipline. Thus, for instance, John Farley's *Bilharzia: a History of Imperial Tropical Medicine*, whose title portends a vast and inclusive sweep, seems to skate across political, epidemiological and disciplinary contexts in pursuit of a thesis which foregrounds notions of a progressive will to global dominance, reflexively damning the ill and the potentially infected to a historiographical wasteland where local action is subjected to the depredations of the ordaining behemoth of global public health.

In this thesis, I examine the control of a particular disease within a defined geographical space, and depict the interactions of a set of international, national and local organisations within the terrain constituted by the prevalence[34] and control of leprosy in Ogoja. However, in contrast to Farley, my focus on demonstrating how relations between a specific locality and the broader world are enacted and constructed, elucidating the strategic significance of leprosy in the context of health and illness and of international medical, political and economic action, allies itself more to the interpretative tendency outlined with reference to Hunt, Olumwullah and Vaughan.

This process seems to promise the removal of medicine from the centre of medical history, but leprosy undoubtedly and unavoidably remains a central component of this enquiry. At the same time, this thesis seeks to evade a certain trend in the history of leprosy which homes in on the construction and meaning of stigma.[35] It would be attractive to focus over-attentively on the variability and severity of stigma in pre-colonial Ogoja, piecing this together with a consideration of whether Catholic missionaries imported, created or transformed stigma with regard to leprosy in concert with Biblical interpretations and preoccupations and with

[34] I thank Lucy Carpenter for alerting me to the distinction between prevalence as an indicator of total disease load within a population, and incidence as an annualised measure of new infection. This distinction was not always maintained in correspondence on leprosy control in colonial Nigeria.

[35] See Gussow (1989), N.E. Waxler, 'Learning to Be a Leper: A Case Study in the Social Construction of an Illness.' In E.G. Mishler, ed., *Social Contexts of Health, Illness, and Patient Care*, (Cambridge, 1981) pp. 169-94, and E. Silla, *People Are Not the Same: Leprosy and Identity in Twentieth-Century Mali*. Oxford, 1998) for examples of this literature.

translations of medieval leprosy lore. This, however, would only serve to inscribe a Manichaean dichotomy onto an archive whose actual preoccupations are with a more exigent and diverse set of concerns.

Rather, the relations which one might interpret as reflecting a stigma with regard to leprosy need to be interrogated within the broader political context of resource access, development and medical provision. From such a perspective, 'leprosy' can be viewed as a construct reflecting a wide variety of historically contingent notions of biology, spirituality and social meaning, notions associated together in the colonial setting by processes of displacement, translation (often with the Bible as its lexicon), and competition. Given this contingency and process-dependence, an *a priori* focus on stigma as either a valid conceptual nexus, or a stable analytical category, would simply by-pass an examination of crucial processes of translation and displacement. I argue that these processes, crucial in the construction of the colonial arena more broadly, need to be excavated for clarity regarding the politics of leprosy. It is in order to distinguish the components of the shifting subjectivities generated and constructed in the processes of leprosy control that I largely excise what I feel to be a pre-emptively generalising reliance on the term 'stigma' from my consideration of the political economy of leprosy control in Ogoja.

Approaches to leprosy were constitutive of the forms and extent of colonial and missionary knowledge about conditions and needs in Ogoja Province. The focus on leprosy did not exhaust colonial and missionary interest in aspects of society in Ogoja, and was conducted alongside the usual raft of agricultural interventions and experiments, geological surveys, quasi-anthropological investigations, educational development and infrastructural innovations which created, mapped and politicised colonial space.[36]

All the same, institutions of leprosy control had a unique role in reorienting the politics of

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[36] See C. Bonneuil, 'Development as Experiment: Science and State Building in Late Colonial and Postcolonial Africa, 1930-1970', in *Osiris*,15 (2001), pp. 258-81, and H. Tilley, 'Africa as a living laboratory. The African research survey and the British colonial empire : consolidating environmental, medical and anthropological debates, 1920-1940', (D.Phil thesis, Oxford, 2001), for analyses of wider patterns in developmentalist statecraft in late-colonial Africa.

place and ethnicity, as a politics of territory and statecraft. In the process, colonial interactions with Africans in Ogoja were charged with novel and complex meanings, as new geographical foci developed in conjunction with leprosy settlements, amid the breadth of employment and community development opportunity heralded by the concentration of medical services. The contexts of leprosy control were endowed with elements of faith, medical innovation, captivity and racial pathology, which need to be explicated in all the complexity and richness of their interaction.

Methodological remarks

From September to December 2000, I visited Ogoja and Enugu to conduct archival research for this study. The undertaking of a study so apparently apolitical in the present-day Nigerian context, and one which certainly seemed remote from the range of pressing contemporary concerns, evinced a sense of surprise among participants in Church and mission and among local people in and around Ogoja. This was complemented by the fact that in some way, for a proportion of those to whom I spoke, 'their story' was being told, which has served as a consistent source of conceptual and theoretical unease over the course of my research.

A number of summaries and accounts exist of the work of the RCM, the MMMs, and the course of missionary leprosy control in Ogoja Province. These accounts have largely been prepared by participant missionaries and, in passing, by Catholic journalists and authors, generally in recognition of major events and anniversaries in Nigerian Catholicism and Catholic mission in Ogoja.[37] The reader of such texts is rapidly familiarised with a recognisable *dramatis personae*, who together rehearse a series of memories and events endowed with a strong sense of personal and communal spiritual significance.

As with any story whose relevance is largely conceived as local, and whose dramas and

[37] e.g. *The Diary of a Medical Missionary of Mary*, (Dublin, 1957); Ogoja Convent Files, 1986 typescript. *A Brief History of the Medical Missionaries of Mary in Ogoja*; the MMM website, http://www.mmmworldwide.org/default.asp?article=Hansens%20Disease, (last consulted, 20th June, 2004); and the excerpts cited from Ó Fiannachta (1982) and Nwosu (1982) on the opening page.

sympathies are enacted and understood at a personal, intimate level, the conduct of a scholarly investigation on such an ideologically loaded and sensitive charitable labour as missionary leprosy control can be a fraught procedure. Having established a working relationship at the MMM archives in Drogheda prior to researching for this thesis, much of my early investigations centred upon informal discussion with MMM participants in leprosy control in Ogoja in order to construct a loose timeline and a thematic outline, an examination of diocesan and convent-related correspondence between Ireland and Africa at the Drogheda archives, and an attempt to identify and secure access to archival resources in Nigeria.

The tense political situation in Nigeria following the end of almost sixteen years of military rule and the holding of democratic elections in 1999 had a number of effects on the conduct of my research. Communication difficulties between Ireland and Ogoja were felt to have been exacerbated as a result of recent political problems in Nigeria, and Irish-based missionaries were unsure at first as to the advisability of travel to Ogoja and Abakaliki for historical research, both from their own perspective, and from mine. Eventually, I was able to make arrangements with Nigeria-based MMMs and the Bishop of Ogoja, Joseph Ukpo, to base myself at the complex which included the St. Benedict's Tuberculosis and Leprosy Hospital, the Moniaya Maternity Hospital, the Good Shepherd Special Education Centre, the Ogoja Midwifery Training School, and the Medical Missionaries of Mary Convent, a short distance from Ogoja Town.

From this base, I was able to visit a number of MMM and Kiltegan sites in Cross River, Ebonyi, and Akwa Ibom States, though by the time of my visit, MMM sites in Ikom, Obudu, and Afikpo had been consolidated at Ogoja Convent, and in the case of Ikom and Obudu, what papers were available to me were also at the convent at Ogoja. This convent has since closed; the MMMs retain a presence at Abakaliki, formerly in Ogoja Province, now capital of Ebonyi State. Due to a variety of practical and political difficulties, while I was able to visit Abakaliki during my stay, I was unable to use documentary material there, and had to rely on duplicated material at Ogoja and at the National Archives, Enugu. Unavoidable force of circumstance meant that, sadly, I was also unable to consult the recently indexed diocesan

archives at Ogoja during the course of my stay.

Major advances in therapeutic technologies for leprosy control, in the 1960s, with the development of clofazimine, and in the 1980s, with the application of multi-drug therapy for leprosy, coupled with the changes wrought by independence, regime change, and war on the administration of leprosy control in Eastern Nigeria, have led to a dismantling of the original, and ostensibly obsolete, structures pertaining to historical leprosy control in the area. This gave rise, in turn, to difficulties in identifying and locating local stakeholders in leprosy control politics. A mid-1990s disturbance, centred on rights to land formerly used by the leprosy settlement at Moniaya, Ogoja, resulting in a number of fatalities and resurrecting a legacy of political bitterness between neighbouring towns in the area, also informed my caution regarding local political issues, as a guest of the diocese and of the mission. At the same time, it left me with a keen awareness of the role of local political forces, largely unfathomed by medical missionaries, in shaping the outline and extent of medical services in the area.

In consultation with medical and missionary staff in Ogoja, and in tune with my own intuitions while in Nigeria, I decided not to conduct oral interviews as part of my research. Though the stigma attached to leprosy across the Ogoja area has historically been variable, the very clearly identifiable nature of my project with leprosy control activities, and the marginal and difficult nature of the economic lives of many inhabitants of Ogoja, made the task of identifying and contacting past patients of leprosy settlements ethically unjustifiable. Though I was party to a wealth of informally proffered information about medical activities in Ogoja, I have used this material as a check on and a guide to my instincts regarding the archival material, rather than as part of my account.

From a local perspective, such as I can claim to intuit, my presence in Ogoja was understood as rather narrowly, if anomalously, medical. Though acquaintance and friendship with senior local Catholics, and with members of the hospital staff, afforded opportunities to broaden my appreciation of local economies, geographies and life-courses, my purpose in Ogoja was

variously interpreted as relating to rural and medical development, Catholic mission, health and hospital inspection, and, most intriguingly, the cure of sickle-cell. The horizons imposed by these understandings will have structured my account in ways which remain opaque to me, while the misinterpretations, and the resulting conversations at cross-purposes, have continually prompted my curiosity and repeatedly piqued my interest regarding the spatial, social, and intellectual context of my enquiries.

While material of relevance to the development of my thesis was available at the National Archives in Dublin and London (Public Record Office), and at Rhodes House, Oxford, the bulk of the archival resource on which my account and conclusions are based consists of material at three locations: the MMM Convents at Ogoja and Drogheda, and the Nigerian National Archives, Enugu. Constraints unique to the indexing and gathering of information at these archives emerge in my account in precisely identifiable ways.

At the time of consultation in 2000, the material I examined in Drogheda had been indexed up to 1962, the silver jubilee of the founding of the MMMs. I consulted files specifically relating to: (i) the relations between the MMM Motherhouse in Drogheda and the Prefecture and Diocese of Ogoja; (ii) the administration and spiritual life of the convent at Ogoja; and (iii) the overall organisation of the MMM mission in Nigeria. This material was organised along categories relevant to the foundation and development of the congregation, and included little of direct relevance to the medical side of MMM work in Nigeria. Much material in Drogheda remained to be examined by me in detail, including files on convents at Ikom, Obudu and Abakaliki, and on the developing spiritual and ideological approach of the MMMs to their medical work. However, my consultation of the detailed guides to this material, written by Sr. Anastasia Taggart, MMM, and the overlap I noted between material in Drogheda and in Ogoja, informed my decision not to return for extensive work in Drogheda. My subsequent visits there concentrated on the identification of articles in the MMM periodical, *The Medical Missionary of Mary*, of relevance to leprosy and Ogoja.

At the convent in Ogoja, the material I consulted was not archived according to any

discernible pattern. It was presented in titled folders, with some titles pertinent to the material therein, and others less clearly so. At times, it was clear that a number of smaller files had been collated in one folder, which retained its title as a vestige of its former purpose within the original filing system. Organisationally, a folder tantalisingly titled 'Ogoja Settlement – early days', gave way to an increasingly differentiated and complex set of groupings, such as 'Bishop McGettrick', 'Dr. J. Barnes: Dr. D. Freeman: Trial Drugs', 'Plans', 'Recurrent Grants: Other Grants', 'Leprosy – Ikom', 'Outstation Clinics – Ogoja and Ikom Divisions'. The overall impression given is of an ongoing re-thematisation of issues of administrative and organisational relevance, itself an artefact of the administrative history of the leprosy scheme.

The coverage achieved in the files varied across the chronological period examined, spiking in the late 1940s, again in the early 1950s, and as Independence approached in the late 1950s. However, the closeness with which the variation seems to track constitutional developments in Nigeria, lulling appropriately in the mid-1950s, suggests, at least obliquely, that the issues of keenest and weightiest interest to those administering leprosy control bore relations to changing administrative mechanisms more broadly.

At the Nigerian National Archives, Enugu,[38] I examined files relevant to medical developments in Ogoja Province between 1945 and 1955, the Ogoja Leprosy settlement to 1955, and leprosy relief in the province between 1936 and 1953, beyond which date the relevant files were no longer available in Enugu. There was some overlap between the material filed at the MMM Convent, and that at the National Archives, which enabled me to extrapolate the tone of official attitudes to missionary leprosy control beyond 1955, but the lull in documentation in the mid-to-late 1950s has both influenced the narrative construction of my thesis, and limited the scope of some of my conclusions, as it became difficult to track the points of contention which underlie my description of late-colonial political space. The impact of these vagaries in documentation is most clearly visible in the consideration of

[38] The Nigerian National Archives are divided among three locations; at Ibadan, Kaduna, and Enugu, corresponding to the three main administrative areas of Western, Northern and Eastern Nigeria, respectively.

statistical material from the files and archives.

I have drawn attention to the inconsistent nature of the documentation, filing, and presentation of material relating to the administration of the RCM Ogoja Leprosy Scheme. My scepticism regarding the usefulness of many of the statistics generated, as measures of prevalence, incidence, or severity of leprosy in Ogoja, has pervaded my approach to structuring the narrative at the heart of the thesis. Given that leprosy and its control existed at the nexus of such a variety of forces, the confusion exhibited in the sources, as to which figures related to which processes and places, is not surprising.

The hasty initial implementation and rapid development of the RCM Ogoja Leprosy Scheme, dispensing with the sort of survey which would directly relate prevalence and incidence to numbers under treatment, and thereby generate a measure of coverage, coupled with the demographic uncertainty cloaking pre-1945 Ogoja Province, tempers the usefulness of the statistics to hand. The intersecting hierarchies of responsibility governing the scheme's operation - mission, local authority, regional medical administration, and colonial government - each with their own onerous and opaque statistical demands, seem to further dilute any level of certainty which might adhere to statistical measures.

Figures made available to the Vatican differ from those sent to the Nigeria Leprosy Service, the Eastern Region Department of Medical Services, or the MMMs in Drogheda. Figures published in missionary magazines often seem to bear only a loose relation to those available from annual reports, while the conflation or separation of figures from Ogoja, Obudu, Abakaliki, and Ikom, according to the vagaries of diocesan administration, the remaking of colonial district boundaries, and the varying level of attention to detail in compiling statistics, cast further doubt on any individual measure given. I keep these considerations in mind in presenting and discussing any statistical material.

One of the labours central to the writing of this thesis has been the wresting of broader resonances of the RCM Ogoja leprosy scheme, and of its story as understood by participants,

from an often reticent and narrow archival record. Exploring the operations and ramifications of spiritual discourse, the intellectual and practical filiations of medical diagnosis and investigation, and the strategic implications of characterisations of Ogoja and its people, of Ireland and its posited Catholicism, and of Britain's imperial intentions, have all contributed to widen the range of methodological tools used to investigate the history of the RCM Ogoja leprosy scheme.

As a result, this account derives from assembled written material pertaining to the administration of religious mission and of leprosy control in Ogoja Province, and more broadly, as and when relevant, to the collectors of the material. Though it is guided in part by conversations and observations made in the course of my research in Ireland and Nigeria, it is unable to systematically reflect dynamics which fall outside the purview of state, colonial and missionary written sources. I have drawn on a wide and varied secondary literature on history of medicine, development studies, British imperial, Irish and African history, political science, geography of health and disease, anthropology, gender studies and history of religion in order to identify lacunae in and facilitate nuanced reading of the archival material at my disposal. My consideration of the reorganisation of spheres of political activity in Ogoja does not presume to exhaustively portray pre-colonial patterns and accommodations for the purposes of contrast with the colonial. All the same, the comparisons between types of colonial change and genres of political process in pertinent scholarly literatures underpin what I feel to be a valid guide to the course and significance of social and political change in Ogoja in the mid-twentieth century.

Thesis summary

In the introductory chapter, I outline the scholarly context in which this thesis grounds its contribution to the existing literature, focusing on the understanding of political action in late colonial Africa, and the reorientation of local politics towards a development-driven agenda, as well as on the intimate contribution of medical and public health thinking to the novel

politics of decolonisation and independence. I also note limitations imposed by the research process on the conclusions it is possible to reach.

Chapters Two and Three develop the thematic and historical groundwork framing study of Irish missionary health care in Africa, and outlining the local contexts in which RCM leprosy control was carried out in Ogoja. Chapter Two, then, begins with an examination of medical thought and rhetorical imaginings surrounding leprosy. This is followed by an exploration of the analogies between Catholic health care in Ireland and in Nigeria, in an attempt to divine the substance or otherwise of claims to Irish exceptionalism in linked domains of imperial and postcolonial history and of the politics of aid and development in the post-1945 world. This examination is contextualised within a broader consideration of Irish Catholicism and the character of Catholic mission in British colonial Africa. This thematic groundwork is complemented by an account of the economic and social history of pre-colonial and early colonial Ogoja, focusing on the role played by systematic misunderstandings of Ogoja, which were operationalised as guides to colonial administration and rule. The chapter concludes with a consideration of the broader political context of post-1945 colonial Nigeria.

In Chapter Three, I detail the forces shaping the interventions of Catholic missionaries within the specific context of colonial Ogoja Province in the period before 1945, and develop a characterisation of these interventions which enables an assessment of the strains of novelty and continuity in the later development of the RCM Ogoja leprosy scheme. The evolution of nascent concerns with leprosy is traced, bringing to the fore the accommodation between colonial administrators and missionaries forged through discourse on leprosy. I assess the status of colonial knowledge of Ogoja, its places, and people in the period leading up to 1945, showing, with reference to the planning process leading to the foundation of a provincial leprosy service, how the systematic misapprehensions of social dynamics across Ogoja and beyond, in part conditioned by the bounding of the province, crucially determined the shape which the RCM Ogoja leprosy scheme took in the early years of its development. I also discern the relation between plans for provincial leprosy control in Ogoja and wartime planning for a Nigeria leprosy service, to be constituted according to a 'clan settlement'

model, which married colonial ideas of ethnicity to unspoken notions of land ownership and territory, imposing a particular and derivative understanding of the relation between ethnicity and territory across the communities of Eastern Nigeria.

Chapter Four examines the construction of mission and religious identities associated with the Roman Catholic Mission's presence in Ogoja Province. Colonial administrative parlance depicted missionary organisations engaged in welfare work as voluntary agencies, and over time a regulatory discourse evolved seeking to determine the appropriateness of evangelical work in grant-aided voluntary agency settings. At the immediate level of the leprosy settlement as a model village, patterns in an idealised Catholic practice, drawing strongly on new and developing Irish norms of spirituality, were refracted onto the social space and hierarchy of the village and the medical establishment. Here, the particular importance of gender differentiation in Catholic hierarchical structure and thought on social and familial organisation play a crucial role in the development of local practices. An examination of the salience of prayer and spiritual communication as an interpretative forum for missionary medical work, presented in this chapter, enables a novel depiction of political process in late-colonial Nigeria. The chapter explores the production process and the propaganda value of the 1948 feature-length documentary *Visitation: The Story of the Medical Missionaries of Mary*, and concludes with a consideration of martyrdom and sacrifice as organising principles of mission.

Chapter Five traces the interaction between colonial administration and missionary enterprises in the development and provision of welfare services in the particular context of leprosy control in Ogoja Province. In particular, I explore how conceptions of the proper relation between labour, taxation, wages and payment for medical services were a subject of constant contention between missionary and colonial officials and workers, and the ways in which this contention co-articulated with determinations about the siting of leprosy services, responses to local medical politics, and considerations of how best to administer the refractory ethnic confection that was Ogoja Province. Using this material, variations in concepts of administration, stewardship, trusteeship and rule can be distinguished, both as

understood by the various European parties to colonial and post-colonial welfare politics, and as negotiated with regard to a variety of contexts of local engagement.

In Chapter Six I look at the role of medical knowledge, as constructed in the curious institutional context of the 'clan settlement' leprosy scheme employed in northern Ogoja Province, in mediating relations between leprosy patients and sufferers, the communities from which they were drawn, in which they lived, and which they constructed in concert with missionaries, the missionaries themselves, both lay and professed, male and female, and scientists in British colonies, Britain, Ireland, and the wider world. Understandings of the significance of the RCM Ogoja leprosy scheme were mediated by discourses on medical research and rural development, while the practical issues surrounding infrastructure and the assembly of requisite *materia medica* were of constant concern from the medical point of view. Surgical techniques and medical treatments related to maternal health and infectious disease necessitated the founding of ancillary clinics alongside leprosy-related institutions, further complicating the relationship between mission and local communities. That the period from 1945 to 1953 was pivotal in leprosy chemotherapy is clear even in Ogoja, where numerous new drugs were trialled, including an Irish-developed compound, B.283, a precursor of clofazimine, used in the treatment of leprosy to this day.

Taken as a whole, Chapters Four, Five and Six explore a set of significant themes pertaining to the early development of the RCM Ogoja leprosy scheme. In the course of disentangling discourses which rationalised British colonial administration as principled and developmental, missionary activity as beneficent and salvational, and medical and public health administration as benign, progressive and scientific, I develop a depiction of European workers in health care in Ogoja which situates their work within a political economy of colonialism and decolonisation.

In Chapter Seven, I show how, in spite of the persistence of antiquated rhetoric about the plight of the leprosy sufferer, the increasing influence of developments in international public health, and the impact of greater funding for development and welfare, altered the

national, imperial and international contexts in which health care interventions and strategies of infectious disease control were conceived and enacted. The notable alterations in the language of stewardship deployed by missionaries involved in leprosy control is closely scrutinised, as Nigerian independence approached, the achievement of complete coverage of leprosy cases in Ogoja seemed close at hand, and the role of local agents in the administration of public health and leprosy control became more pronounced.

In conclusion, the destabilisation and recomposition of narratives surrounding welfare stakes and politics in mid-twentieth century Nigeria, conducted by means of focus on ostensibly marginal missionary groups, welfare enterprises and colonial provinces, will be demonstrated to significantly affect accounts of late-colonial Nigeria, with relevance to broader analyses of colonialism in Africa.

Chapter Two - Broadening contexts for a critical history of leprosy control

Assessing 'leprosy' in medicine and rhetoric

> The study of the origin and spread of leprosy from earliest times has afforded a wide field for medical research; its romance has inspired author, preacher, artist, and poet with some of their greatest themes.[1]

This chapter will consider the historiography of leprosy in detail, outlining common approaches to problems in the history of leprosy, and refining interpretative techniques in order to situate leprosy and thought about leprosy in contexts pertinent to late colonial society and politics. The theoretical process evolved here contrasts disease-focused theories of institutional space and clinical practice with narratives accounting for the broader social implications of leprosy control, and enables the scholar to construct a responsive account of leprosy control in Ogoja, eliciting the significance of mission, medicine and locality thoroughly and in specific detail. Describing the broader context of Catholic mission in the British Empire, with specific reference to Eastern Nigeria and Ogoja, and outlining the tentative engagement of the colonial state with the Ogoja area, I propose an alternative reading of the historiography and history of leprosy, which both underpins and is substantiated by subsequent chapters.

Accepting that appreciation of the nature of leprosy is itself historically contingent, and that the disease as yet poses unsolved epidemiological, clinical and physiological puzzles, it will all the same be useful to outline current thought on the biological characteristics of leprosy. The definition offered by Bryceson and Pfaltzgraff is both clear and concise in this regard:

> Leprosy is a chronic infectious disease of man caused by *Mycobacterium leprae.*
>
> Leprosy is essentially a disease of peripheral nerves but it also affects the skin and sometimes certain other tissues, notably the eye, the mucosa of the upper respiratory tract, muscle, bone and testes.[2]

Further, the diagnostic and classificatory indications given by McDougall and Yuasa show

[1] E. Mackerchar, *The Romance of Leprosy*, (London, n.d. [1949]), p. 5.

[2] A. Bryceson and R.E. Pfaltzgraff, *Leprosy*, (Edinburgh, 1990, 3rd ed.), p. 1.

the variability of the disease, of its presentation and of its severity, as well as indicating common misattributions resulting from confusion with other conditions.[3]

Changes and inconsistencies in the classification of leprosy over the past century make it difficult to accurately represent the epidemiological profile of the disease. This has encouraged speculative theories of its origin and spread. More recent classifications separate the diagnostic procedure from the observed immune reactions, identifying a simple diagnostic distinction between paucibacillary (PB) and multibacillary (MB)[4] leprosy, a distinction roughly correlating with a spectrum of immune reactions ranging from tuberculoid, commonly characterised as less severe in appearance and indicating a weaker immune reaction, to lepromatous, where the reactions are more extreme.[5]

This novel separation of diagnosis from clinical symptoms reflects more faithfully than prior classifications the paramedical contexts in which leprosy work has often been carried out. Historically, classifications effectively yoked contexts for the treatment of the disease to the clinical expertise of the physician, and, from the perspective of the historian, under-represented the importance of nurses and 'assistants' in organising and administering the treatment of leprosy.[6] These recent shifts in techniques of classification also help unbind the tight relation of diagnosis in leprosy to individual debility and deformity, a relation which has so frequently characterised medical, imperial and missionary rhetoric of leprosy, which obscures broader epidemiological trends, and which forestalls the thorough investigation of these trends.

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[3] C. McDougall and Y. Yuasa, *A New Atlas of Leprosy: a Pictorial Manual to Assist Frontline Health Workers and Volunteers in the Detection, Diagnosis and Treatment of Clinical Leprosy*, (Tokyo, 2000).

[4] PB refers to presentations with 5 or fewer skin lesions and where a skin smear is negative for *m. leprae*, while MB refers to presentations with more than 5 lesions and a positive skin smear, giving both clinical and bacteriological options for the classification of the disease. The treatment regimen adopted depends on the classification.

[5] McDougall and Yuasa, (2000), p. 35, and S. Browne, *Leprosy*, (Basle, 1970), ch. VI, indicate the as yet not completely understood complexity of immune reactions in leprosy, the former text noting the paradox that '[f]ar from being helpful or protective... reactions are often damaging to skin, nerves and other tissues.'

[6] L. Beer Kumwenda, *The Development of UMCA Medical Work in Northern Rhodesia, 1910-1950, with Special Reference to the African Medical Personnel*, Basler Afrika Bibliographien Working Paper, (Basle, 2000) addresses the crucial role of paramedical staff in rendering biomedical intervention acceptable, supplementing a copious literature on the importance of African agents in the expansion of missionary Christianity, exemplified in R. Gray, *Black Christians and White Missionaries*, (New Haven, 1990), and E. Isichei, *A History of the Igbo People*, (London, 1982).

In post-1948 classifications operative for most of the period under investigation in this thesis, and prior to that offered by McDougall and Yuasa,[7] the more lepromatous presentations of the disease were directly and absolutely associated with open and infective skin lesions, while tuberculoid cases were classed as 'closed' and non-infective. Browne identified a clinical course which i) may progress from indeterminate (or pre-tuberculoid) through tuberculoid, and borderline,[8] to lepromatous, designating the severity of neural infiltration and skin coverage, the shape and pattern of macules, raised patches, and nodules, ii) may emerge at any point along this continuum and either arrest or progress in severity, and iii) may lead to variable patterns of neural and tissue damage.[9] Some correspondence between the relative proportion of tuberculoid and lepromatous leprosy in a population, and the pattern of the spread of the disease, has been attributed to whether leprosy is epidemic or endemic in an area, with lepromatous leprosy being more significant in leprosy-endemic areas.[10]

Throughout the period under investigation, the inability to cultivate leprosy *in vitro* (in contrast to bacteriologically similar strains of *Mycobacterium tuberculosis*), the insufficiency and uncertainty of the diagnostic procedures, and the difficulty of ascribing the protean manifestations of the disease to any one diagnostic class or another resulted in unstable and shifting understandings of leprosy, uneasily co-articulated with a variety of 'romantic' impulses and discourses regarding and influencing its control and management. Browne discerned the problem with precision, writing:

> In the past, the study of leprosy has been hindered by failure to distinguish between the various forms of the disease, particularly in respect of clinical signs, infectivity, therapeutic trials and relapses. The clinical appearances show wide variations from one patient to another as a result of the chronic and slowly-progressive nature of the disease, which is moreover unique in that one all-embracing (and historically equivocal) name covers many diverse concepts.[11]

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[7] This date corresponds with the 5th International Leprosy Congress in Havana, which adapted the 1946 Pan-American Classification into a standard descriptive classification of the type Browne follows.

[8] Bryceson and Pfaltzgraff (1990) further divide borderline into borderline tuberculoid and borderline lepromatous.

[9] Browne, *Leprosy* (Basle, 1970), ch. IV.

[10] Bryceson and Pfaltzgraff (1990), p. 213. This again underlines the paradoxical relation between immunity and presentation, in that areas where leprosy is newly endemic seem to have a higher incidence of tuberculoid leprosy.

[11] Browne (1970), p. 10.

It is unsurprising, then, that the history of leprosy presents the scholar with a succession of paradoxes. Both as conceived and written, and in terms of the events and processes it seeks to represent, this history is mired in contradiction and misunderstanding. This results in part from what Obregón describes as the relative uninterest of professional historians in leprosy,[12] with the consequence that much of the existing commentary on the history of leprosy is written by individuals engaged in leprosy control, whether as medical practitioners or as propagandists. The historiography which has evolved as a result tends to be both theoretically impoverished and largely uncritical. It continually reinforces persistent ideological markers as to the character of the disease and the patient suffering of the afflicted. It habitually constructs narrative tropes based on the repeated interpolation of Biblical and ancient mythologies on leprosy and healing with institutional histories and rationales, the erecting of continuities between incongruent nosologies through the ages, and the reiterated articulation of narratives of exclusion and repulsion, all counterpointed with a blend of medical and almonary heroism and dedication.

The *a priori* inscription of expressions of pity and optimism[13] into the historiography makes it difficult to operationalise the sort of critical distinctions necessary to integrate a history of leprosy with broader histories of medicine and imperialism. The emotionally charged rhetoric underlying modern leprosy advocacy reiterates notions of leprosy as a 'disease apart',[14] while the valorisation of charitable and rights-based approaches to the history of leprosy in what is held to be a secularised post-1945 medical aid and development sector limit the critical leverage of many more recent contributions to this historical literature. Indeed, while much work has been done to document medical and scientific developments in

[12] D. Obregón, 'The anti-leprosy campaign in Colombia: the rhetoric of hygiene and science', in *História, Ciências, Saúde - Manguinhos*, 10, supp. 1 (2003), p. 180.

[13] Mackerchar (1949), P. Myers, *Uplifted Hands: the Story of Leprosy*, (Tralee, 1951), P. Feeny, *The Fight Against Leprosy*, (London, 1964) demonstrate the discursive function of pathos and emotion in identifying problems of leprosy control with representations of the 'extreme case' of severely deformed or disabled leprosy sufferer.

[14] Gussow (1989), ch. 10 traces the evolution of leprosy exceptionalism though the exercise of missionary rhetorical creativity in the late nineteenth century, while Obregón 'The anti-leprosy campaign in Colombia', (2003) provides an alternative Latin American trajectory for the dissolution of leprosy's 'apartness'.

leprosy control,[15] and many histories of hospitals have been written,[16] this historiography fails to systematically grapple with the social and political ramifications not only of the incidence of and attitudes to leprosy, but of the structures evolved for its treatment and control, and the organisational externalities of these structures.

As a consequence, an unusually pronounced separation has emerged between leprosy as a historiographic artefact, and leprosy as a disease entity in its physical and social context. This separation is contaminated by a terminology shared between medical staff, missionaries, and historians - as hinted at by Browne[17] - a separation which has tended to deepen the confusions attending the history of leprosy. The historiographic construct, 'leprosy', appears to remain somewhat fugitive from scholarly consideration, often evading the sort of thorough investigation which might bring clarity to accounts of its social, political and historical significance. This historiography, intolerant of nuance, is unable to mount or to support a critical investigation of the embeddedness of the disease entity, as illuminated with reference to germ theory, to institutions of segregation and medical charities, to envisionings of the tropical, to epidemic control measures, and to relations of political domination.

Throughout their book,[18] intended as a primer for clinical practice in leprosy control, Bryceson and Pfaltzgraff present series of questions addressing the still proliferating puzzles of leprosy and its control. The generic character of these puzzles suggests that historians might usefully pay attention to repeatedly contested fields in the epidemiology, pathology, and therapy of leprosy, examining the extent to which such contestation undermines the

[15] O.K. Skinsnes, 'Notes from the history of leprosy', *International Journal of Leprosy*, 41, 2 (1973), pp. 220-45 offers a detailed and highly individual chronology of thought about, practice regarding, and literature on leprosy, dividing the most important contributions to the understanding of leprosy between 'Pre-Century of Progress', and 'Century of Progress'. The transitional date, 1873, represents the discovery of the leprosy bacillus by Armauer Hansen in Norway.

[16] J.N. Chukwu and U.M. Ekekezie, *The Leprosy Centre Uzuakoli (1932-1992)*, Owerri, 1992, and O.J. Gbadamosi, E.M. Davis, and others, *The Story of Qua Iboe Church Leprosy Hospital, Ekpene Obom, 1932-1988: a Symbol of Love and Sacrifice*, (Etinan, 1988) epitomise this genre in the Nigerian context. As with the Skinsnes article, commemorating a centenary, both works commemorate an anniversary – sixty years of the hospital's foundation in the case of the former, and one hundred years of the mission's foundation in the latter case.

[17] Browne (1970), p. 10.

[18] Bryceson and Pfaltzgraff (1990), passim. Each chapter is conceived as an exposition of current thought on an aspect of leprosy, considered biologically, socially, clinically, and administratively. The presentation is sensitive to the manifold uncertainties surrounding the disease, a sensitivity reflected in the series of provocative questions with which each chapter ends.

making of neat chronologies, and using these considerations to unmask the political motivations of progressivist narratives foregrounding one or other historical model of leprosy control and its efficacy.

In recent years scholarly historical techniques have been employed more frequently in attempts to disentangle and reinterpret the multiple elements from which the story of leprosy has been composed. The work of Diana Obregón on the making of the medical profession and liberalism, and the contest for state power in Colombia, in which attitudes to leprosy and its sufferers played a crucial role, and of Michael Worboys on the role of the British Empire Leprosy Relief Association in mediating charity and scientific endeavour in the context of the British Empire pre-1940, are significant in this regard.[19]

To date, the perhaps necessary focus of scholarly investigations such as these on early twentieth century evidence and events have led to overly speculative assessments of the more recent history of leprosy. The increasing internationalisation of public health has been assumed to hold true across the board for late-twentieth century disease control – an assumption which has not been adequately probed in the case of leprosy. Any history of leprosy control in the mid- to late- twentieth century must query the parameters of this internationalisation, examine the organisational shifts and feints which make the recomposition of this history so problematic, and subject the claims of clinical workers to critical scrutiny in order to discern the writ of policy amid the prescriptions of clinical science.

Though this thesis presents the history of the development of an institutional framework for the identification, treatment and cure of leprosy in only one particular geographical setting, the characteristics of this institutional framework derive from and are informed by a great variety of religious, missionary, medical, administrative and social contexts. Using an analysis of the sense of place and identity of the mission involved in leprosy control in

[19] See D. Obregón, 'The State, Physicians and Leprosy in Modern Colombia,' in D. Armus, ed., *Disease in the History of Modern Latin America: From Malaria to Aids*, (Durham, NC, 2003), pp. 130-57, and M. Worboys, 'The Colonial World as Mission and Mandate', (2001).

Ogoja, and of the idiosyncratic imposition of colonial rule in Ogoja, I discern how changes in attitude to leprosy and its control were reflected, interpreted, and implemented in the evolutionary course of a single medical enterprise.

It is my contention in this thesis that the history of religious involvement with medical and welfare work in Ireland, as well as the development of a broader Irish Catholic missionary movement, are crucially constitutive of issues of staffing, funding, publicity and administration of the northern Ogoja leprosy control programme. In the Nigerian context, competition between missionary organisations determined the spatial distribution of many forms of welfare service, with leprosy being seen as of particular interest to missionaries. Issues in medical therapy contributed greatly to the pace of development of leprosy services, their spatial distribution, and the form these services took as therapeutic technologies and emphases were transformed by medical research and practice in Eastern Nigeria and further afield.

Relations between missionaries and regional, colonial and national, and international administrative bodies with responsibility for government and healthcare helped determine the scope and success of leprosy control, in terms of providing material assistance and mediating relations with local communities, and mandating forms of therapy and epidemiological responsibilities. The structure of the encounter of the putative leprosy patient with the apparatus of leprosy control, and the relations between communities of leprosy patients and the communities in which they had lived prior to identification with missionary leprosy control, were critical to the continued existence, acceptance and success of the northern Ogoja leprosy control programme.

Irish Catholicism and the character of Catholic mission in Africa

The means by which Catholic missionaries found themselves in the position of providing leprosy services in Ogoja Province were predicated on a variety of cultural and political

shifts in Irish Catholicism originating in the nineteenth century when Ireland still formed part of the United Kingdom. The potential significance of the Irish component to Nigerian missionary Catholicism is signalled by Ajayi, in reference to the predominantly French Catholic missions of the late nineteenth century, writing that political transformations in empire in Africa meant that missionaries

> were even more than before closely allied with the national interests of their country. For a while this intensified the rivalry between French Catholics and British Protestants. But the Catholic Fathers soon adjusted themselves to the idea of working in a British colony. They brought in Irish Fathers, equally Catholic and more at home in British territory, and they never lacked sympathetic Catholic officials in the Lagos administration.[20]

The perceived importance of Irish missionaries is underlined by Ayandele, who comments on the strategic innovations which underpinned their evangelical success in Eastern Nigerian society. Particular attention is paid to the work of Joseph Shanahan in reorienting Catholic missionary practice from a slave-focused *reduction* (Christian village) strategy based on Jesuit missions in Paraguay, to a schools-based strategy which employed government grants to provide education in Igbo areas in Eastern Nigeria.[21]

Shanahan's prior career in France and Ireland had seen him deeply involved in education. A member of the French-based Holy Ghost Fathers,[22] he taught at Rockwell College in Ireland before travelling to Nigeria in 1902. The success of the Holy Ghost schools in Ireland derived in large part from their ability to insert themselves in an educational system which

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20 J.F.A. Ajayi, *Christian Missions in Nigeria, 1841-1891: the Making of a New Élite*, (Evanston, 1969), p. 234.

21 E.A. Ayandele, *The Missionary Impact on Modern Nigeria, 1842-1914: a Political and Social Analysis*, (London, 1966), pp. 300-02. Though the Catholic Church lagged behind the Church Missionary Society in the provision of secondary education and teacher training in the 1920s and 1930s (see E.A. Ayandele, *Nigerian Historical Studies*, (London, 1979), pp. 183-84), the willingness of Catholic missionaries to accept government grants in spite of government refusal to countenance compulsory religious instruction (a sticking point for the Church Missionary Society), and the insistence on the part of the Catholics that instruction be in English, rather than in the vernacular, greatly aided the expansion of the Catholic primary school sector, which was seen as more equipped to provide the collateral material and social benefits associated with western education and English-language literacy.

22 E.M. Hogan, *The Irish Missionary Movement: a Historical Survey, 1830-1980*, (Dublin, 1992), ch. 6. The Congregation of the Holy Ghost, also known as the Spiritans and identified by the abbreviation C.S.Sp., were founded in France in 1703, and gained an early reputation for 'doctrinal orthodoxy and educational excellence'. Surviving the French Revolution with difficulty, its merger with François Libermann's Congregation of the Holy Heart of Mary in 1848 brought a new missionary energy to the work of the organisation. In Ireland, its boys' secondary schools founded in the second half of the nineteenth century - Blackrock College and St. Mary's, Rathmines in Dublin, and Rockwell College in Co. Tipperary - quickly gained repute as among the best in the country, laying the grounds for effective publicity for missionary recruiting in Ireland by the beginning of the twentieth century.

had evolved within a political dispensation perceived to disadvantage Catholics.[23] Along with colleges such as Clongowes Wood, Castleknock and Belvedere, the Holy Ghost colleges in Dublin and Tipperary embraced the classical curriculum outlined in the Intermediate Education Act of 1878 and placed highly in the examinations through which entry into the non-denominational Royal University, and subsequently into the professions, were regulated.

While Shanahan's insights into commonalties between Igbo religiosity and Christianity are readily acknowledged,[24] less attention is generally paid to the potential structural similarities of Catholic experiences of particular welfare and educational services in Ireland and evolving Catholic services in eastern Nigeria. The desire of the clergy to police and control the development and ethos of these services, as well as the pragmatic latching of government funding to religious staffing and administration of schools, hospitals and poor relief, bear comparison in the Irish and Nigerian situations. Furthermore, the bridging experience of the Holy Ghost Fathers, at once startlingly successful in the Irish educational context and the pre-eminent recruiters of Irish missionaries in the twentieth century,[25] suggest the possibility of an even stronger link between the Irish and Nigerian experiences.

The suggestion that isometries existed between Irish and Nigerian experiences of Catholicism does not imply that there were not significant tensions, akin to those which more commonly marked imperial encounters, implicit in relations between Irish missionaries and Nigerians. The attitude of Irish missionaries to the formation of an indigenous clergy is often excoriated by commentators on mission. Hogan portrays an Irish missionary contingent subsisting on imported food, living in brick houses akin to hill-stations, and returning home regularly,[26] a portrait attested to by Adrian Hastings with reference to the 1950s when

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[23] S. Pašeta, *Before the Revolution: Nationalism, Social Change and Ireland's Catholic Élite, 1879-1922*, (Cork, 1999), p. 33. Pašeta writes that '[m]any Catholic commentators had come to view Ireland's education system as an obstacle course and the intermediate system represented yet another hurdle that had to be overcome.'

[24] Ayandele (1966), p. 265

[25] Hogan (1992), p. 78.

[26] Hogan (1992), p. 163. In respect of this portrait, it must be said that many individual biographies, Shanahan's foremost among them, depict a strong and engaged commitment to mission amid difficult and unfamiliar conditions.

> churches almost everywhere were still overwhelmingly dominated by missionaries whose evening conversation was of Irish, American or Quebec politics, while smoking Dutch cigars and surviving with the help of tinned food.[27]

In the light of this, it was unsurprising that many observers of Protestant mission professed shock upon hearing that efforts were in progress among Catholics to train an indigenous clergy.[28] Felix Ekechi typifies Catholic missionary policy in Nigeria as predicated on a need to exert power and dominance, especially with regard to the range of activities of their followers, further linking this tendency to a desire among the Irish to preserve and replicate their own position as Nigeria's Catholic missionaries *par excellence.*[29]

Yet, seen within the context of the hierarchically-led Irish Church, the attitude of Irish religious[30] to their Catholic public seems again not entirely different in the Irish and Nigerian situations. Perhaps it is in the context of the nineteenth and twentieth century Irish Catholicism that the approach of Irish missionaries to the formation of African religious, and training of African staff for the administration of welfare services is best analysed. The notion of hierarchy, and the devotionally-inflected repositioning of religious observance, mediated in great part by professed religious, were trademarks of Irish Catholicism which to some extent obviate the comparison with broader trends in British religion and mission. While there is indeed a British and imperial context for transformations in Irish Catholicism, in many respects, the comparison between forms of mission often seems rooted in a monolithic conception of Britishness, which elides the significance of the varieties of Irish experience of political and cultural life under Westminster rule, and the way in which these experiences continued to shape Irish Catholicism and Irish Catholic mission throughout the twentieth century.

To state this is not to deny the shortcomings of Roman Catholic mission in Nigeria in training an indigenous clergy; after all, this perception is borne out by the evidence.[31] Nor is

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27 A. Hastings, *African Catholicism: Essays in Discovery*, (London, 1989), p. 9.

28 B. Sundkler, *The Christian Ministry in Africa*, (London, 1960), p. 76, cites the surprise of one missionary and theological expert, when presented with the fact that there were at least 200 African Catholic priests in the country in which he worked; he had thought there were none.

29 F. Ekechi, 'Studies on mission in Africa', in T. Falola, ed., *African Historiography: Essays in Honour of Jacob Ade Ajayi*, (London, 1993), p. 157.

30 See glossary.

31 E.C. Amucheazi, *Church and Politics in Eastern Nigeria, 1945-1966: a Study in Pressure Group Politics*,

it to propose that expressions of racism were absent from the Irish missionary record; Ekechi documents a number of these, dating from 1910 through to the 1950s, in his account of the missions and the development of an African clergy.[32] Rather, the expression of power and control by missionaries over their followers must be understood not simply in a colonial context, as an expression of dominance over a politically subject Nigerian population, but also in an Irish and British context, where an important and productive local trend in Catholicism developed hegemonic hierarchically-based forms which were either entirely alien to, or at most less emphatically articulated within British Protestant denominations and traditions. To do otherwise would be to misread the nature and impact of Irish Catholicism, and to misconstrue the texture of the broader missionary enterprise in Nigeria.

The growing sense that there existed something which could be denoted an 'Irish missionary movement' is underlined in an address given in 1945 in honour of departing missionaries, by Arthur Conway, President of University College, Dublin at the Holy Ghost Missionary College in Dublin. Conway spoke of Irish missionaries as 'living proof that even if Ireland lacked a vast material empire, yet she was great as a mother nation, sending her sons to all points of the globe.'[33] This statement adds piquancy to Ekechi's reflection regarding the nineteenth century missionary efflorescence, that the missionary enterprise writ large must be characterised with reference to political and commercial changes in Europe.[34] While it is difficult to relate Irish missionary enterprise to a set of imperial aims or ambitions, it is indeed intimately related to a set of nationalist political goals articulated in a specifically Irish context.

The intellectual parameters of this political articulation, and the missionary movement which it in part generated and continually informed, are given short shrift by numerous observers.

(Lagos, 1986), p. 36 notes a complete absence of African priests in Ogoja diocese by 1958, where the Catholic Church had maintained a continuous presence since the early 1930s, with four African priests in Calabar diocese, and twelve in Onitsha (in comparison to 102 European priests), both considerably longer established. Amucheazi tempers the starkness of this situation with the observation, bolstered by Hogan (1992), p. 166, that the long training period required of Catholic clergy, together with the commitment to celibacy, may have lessened the appeal of training for the Catholic clergy among Eastern Nigerians.

[32] Ekechi (1993), pp. 156-59.

[33] 'Editorial', *Missionary Annals*, 28, 2 (Feb. 1946), p. 3.

[34] Ekechi (1993), p. 146.

While Joe Lee comments on the general shortcomings of intellectual and cultural life in post-independence Ireland at great length,[35] the criticism is particularised and levelled at the Irish missionary movement itself in *Herder Correspondence*, a religious affairs periodical edited during the 1960s by Desmond Fennell. In a rumination on what is judged as the unreflective nature of Irish missionary practice, it is stated that

> the Irish missionary movement hitherto has been a combination of Irish vitality, generosity, skill in human relations, intellectual incuriosity, and general mental uncultivatedness with Anglo-Saxon pragmatism. Its predominant spirit has been that of the man who hacks his way into a burning house to rescue people trapped there... Unreflective, rushing to answer call after call of dire need, working under the tyrannous pressure of necessities seen as urgent and unlimited, the Irish missionaries have not paused to get to know themselves and the specific culture... which they brought with them and embodied. They have not taken the time off to survey the human landscape of their endeavours, to study its contours.[36]

Bearing in mind the rapid time-frame of the evolution of Irish missionary enterprise, and the repeated shocks to which it was subject amid the buffeting of international, imperial and post-imperial politics, and the reorientation taking place in Catholic thought through the twentieth century, it is difficult to determine in what sense the notion of an Irish missionary movement as such is meaningful.

The recognition, supported by Hogan[37] and by Richard Quinn,[38] that Irish missionaries were often in direct competition with one another for access to Irish resources, while acting in almost complete mutual isolation beyond Irish borders, also does much to temper the notion that the outflow of Catholic missionaries from Ireland constituted anything so concrete as a 'movement'. Coupled with the sense that no strong intellectual identity or *esprit de corps* was being generated by their shared labours, fragmented as they seem to have been in application, if not in motivation, it is clear that any meditation on the role of Irish missionaries on developments in imperial and post-imperial politics and in the evolution international aid will need to examine the work of such missionaries with closer attention to specific practical

[35] J.J. Lee, *Ireland 1912-1985: Politics and Society*, (Cambridge, 1989), ch. 8, 'Perspectives', gathers together Lee's insights into the adjudged failures of the Irish political, clerical, and intellectual classes to modernise and develop the Irish state.

[36] Desmond Fennell, ed., *The Changing Face of Catholic Ireland*, (London, 1968), pp. 148-49. The editor's note claims the articles from *Herder Correspondence* reproduced in the text are the joint work of a team of researchers, writers and correspondents - this should be kept in mind relating to comments attributed here to Fennell.

[37] Hogan (1992), p. 172.

[38] R.F. Quinn, with R. Carroll, *The Missionary Factor in Irish Aid Overseas*, (Dublin, 1980), pp. 28-29.

undertakings in particular locations.

It is perhaps true to say that much of the work of the Catholic Church in Ireland, and of its missionary workers overseas, is most easily measured in terms of practical achievement - Hogan cites the Irish strategy of using educational provision as a substitute for the well-articulated and professional approach to apostolic technique and philosophy of the White Fathers in matters of evangelisation, and the renown of the Irish in the construction of 'solid chapels and churches'.[39] The degree of practical innovation generally attributed to Irish workers within the broader Catholic missionary enterprise is seen by Fennell as structurally linked to the literary and intellectual unproductivity of the Irish missionary movement. In this unsatisfactorily rigid view, the link is demonstrated by the chaos of non-coordination among missionary bodies, and a curiously materialist spirituality – common to lay and religious alike - born of the difficult political circumstances of modern Irish Catholicism.

The portrait of Irish mission can be disaggregated further, and problematised somewhat more productively when one takes into account the differing experiences of men and women as Catholic missionaries. Again, the distinctions were rooted in the evolution of Irish practices; specifically, the remarkable expansion in the numbers of women religious and convents in the nineteenth century. The net effect on missionary enterprise is neatly and starkly summarised by Joseph McGlade, writing in 1967:

> The story of the work of Irish sisters on the missions is always the same, and yet almost always without limit in its variety. In brief, the sisters do nearly everything which does not require the power of orders.[40]

The involvement of women Catholic religious in institutional healthcare in Ireland had evolved hand-in-hand with the growing 'devotional revolution'[41] during the nineteenth

39 Hogan (1992), p. 163.

40 J. McGlade, *The Missions: Africa and the Orient*, (Dublin, 1967), p. 48.

41 The thesis that Irish Catholicism witnessed a devotional revolution in the nineteenth century was first advanced in E. Larkin, 'The devotional revolution in Ireland, 1850-1875', in *American Historical Review*, 77 (1972), pp. 625-52. The degree to which the transformation in religious expression involved contending cultures of Catholicism or was led and wrought by a small group of clergy has been a matter for study and debate since. However, there is general acceptance that a transformation occurred, resulting in new and powerful institutional and devotional forms.

century. The foundation of St. Vincent's Hospital in Dublin in 1834 by the Sisters of Charity, complemented five previously extant Protestant voluntary hospitals in the city[42] and betokened a new relationship between Catholic religious and the Irish public. Contributing to and building on a new religious sensibility in Ireland in the second half of the nineteenth century, when Catholic religious enjoyed a much greater degree of visibility, and a more institutionalised and ritualised expression of Catholicism replaced a locally-focused peasant religiosity,[43] institutional innovations by women religious did much to bring the Catholic Church in line with nationalist politics and aspirations in pre-Independence Ireland, though often in controversial circumstances.[44] These institutions were also often the focus of political struggle, in a way which is in sharp distinction to the problems of the Church in France, where anti-clericalism forced Catholic organisations very much onto the political back foot in the early years of the twentieth century,[45] and effectively decoupled a Church with strong institutional roots in nursing and education from its means of exerting political influence.

Mary Peckham Magray, writing about the transforming effect on the mobilisation of women in Irish religious life, and the forms this mobilisation took, convincingly makes the point that

> ..despite the modifications that have been made to the devotional revolution thesis... a transformation of Catholic institutional structures and practices [in Ireland] did occur during the course of the nineteenth century. By 1900, the result was, first of all, an outwardly more devout population that [practised] its religion in impressive new churches and educated its children in an entrenched Catholic school system and, second, the proliferation of a network of Catholic social welfare institutions such as hospitals, orphanages, refuges, and reformatories.[46]

With regard to the role of religious women in the practice of medicine, the early twentieth century presented a variety of contradictory trends in Canon law.[47] A prohibition on religious

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[42] M.P. Magray, *The Transforming Power of the Nuns*, (New York, 1998), p. 80.

[43] See J.J. ó Ríordáin, *Irish Catholics: Tradition and Transition*, (Dublin, 1980) for an attempt to situate persistent and superseded forms and traditions of pre-Famine Irish Catholic spirituality amid the growing social and political engagement of Catholic religious during and since the nineteenth century.

[44] Pašeta (1999), chs. 1 and 2 outline the political controversies surrounding second- and third-level education in late nineteenth and early-twentieth century Ireland, the deliberations and dilemmas arising therefrom likewise exercising professed religious and educated lay Catholics.

[45] Ruth Harris, *Lourdes: Body and Spirit in the Secular Age*, (Harmondsworth: Penguin, 1999), describes the development of a Catholic discourse in medicine very much at odds with the instrumentalist, institutionally-based discourse in Ireland.

[46] Magray (1998), pp. 4-5.

[47] See glossary. It should be pointed out that prior to the Second Vatican Council and the subsequent ecumenical mandate, the word 'Christian' in Catholic parlance commonly related to Catholic issues alone.

providing assistance in childbirth and attending women in maternity homes dating from 1901, was augmented in 1917 by the publication of the *Code of Canon Law*, forbidding the practice of medicine and surgery by religious.[48] While nursing sisters were encouraged by papal declaration to take state examinations after 1911,[49] the lifting of the prohibition on religious sisters practising as maternity nurses and midwives did not come about until 1936, an event which also signified the liberalising of dispensations for medical and surgical practice.[50]

At the same time as these prohibitions were creating difficulties for the nascent movement towards missionary Catholicism building steam in Ireland, a number of women were developing strategies to combine religious commitment with a medical vocation. Acting as a bridge between the institutional innovations of the nineteenth century, and the internationalist aspirations fostered by the Irish missionary movement which was reaping the benefits of British colonial expansion by superseding French Catholic missionary presence in British East and West Africa, women such as Mother Kevin in Uganda, Agnes McLaren and Margaret Lamont, Scottish converts to Catholicism who trained as doctors and harboured missionary aspirations, and Mary Martin, a wartime VAD nurse and 1920s missionary worker in Nigeria, all attempted to secure opportunities to blend medical missionary aspirations with a vocation to religious life.

In Martin's case, the early 1930s were alternately difficult and encouraging. A silver jubilee publication of the Medical Missionaries of Mary, likening the development of the congregation to a fugue, with subject, theme and counterpoint, outlines the problems faced:

> The counterpoint of the cross was very marked in those years - the uncertainty as to the ultimate decision of the Holy See [regarding a ruling allowing religious to do surgery and obstetrics], the difficulty in getting girls to join in a plan as yet vague, the difficulty of training in the Religious life while yet in a lay setting.[51]

A meeting with the Nuncio Apostolic in Ireland, Paschal Robinson (whose secretary Antonio

[48] Hogan (1992), pp. 106-07, attributes this to 'a fear that the practice of certain medical and nursing skills could constitute a threat to chastity and consequently to vocation'

[49] Hogan (1992), p. 110.

[50] Hogan (1992), pp. 107-08.

[51] Medical Missionaries of Mary, *Medical Missionaries of Mary: Covering the First Twenty Five Years of the Medical Missionaries of Mary, 1937-1962*, (Dublin, 1962), pp. 34-35.

Riberi was later Apostolic Delegate to East and West Africa) confirmed the sympathies existing among many senior clergy for Martin's plans. In 1934, Martin and a number of colleagues began to participate in the life of a new French Benedictine community in Glenstal, Co. Limerick,[52] receiving spiritual formation and training in the Benedictine rule, and performing domestic duties in the running of the monastery.[53]

From the Nigerian point of view, the success of Mary Martin and her supporters in founding the Medical Missionaries of Mary (MMMs) in Port Harcourt, Nigeria in 1937, and attracting strong episcopal support in Africa and in Ireland, set the scene for the involvement of women religious in the administration of the RCM Ogoja Leprosy Scheme. Close in age and social background to many of the priests of the St. Patrick's Missionary Society (Kiltegan),[54] the MMMs worked in close association with Kiltegan priests both in Nigeria and in Ireland.[55] The support and involvement of the MMMs was vital to the early success and continued development of the Ogoja Leprosy Scheme, decisively influencing the character of the scheme so carefully elaborated by Dr. Joe Barnes.

Taking into account the internal differentiations in Catholic mission, between Irish and non-Irish, between separate orders and dioceses, and separate colonial and national administrations, and between male and female, lay and religious staff at a particular mission, confronts the scholar with a number of critical questions which shape the parameters of an enquiry into the history of missionary leprosy control. For the purposes of this thesis, the questions with the greatest bearing include: (i) how did the internal financial, ethnic and gender politics of mission affect the development of leprosy control in Ogoja and how did the peculiarities of Ogoja as a colonial construction impact on the construction of mission identity?; (ii) how can one model the interactions between Ogoja and the world at large as

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52 Medical Missionaries of Mary (1962), pp. 35-36, 45.

53 Personal conversation with Sr. Anastasia Taggart, MMM, 1999 and 2000

54 The St. Patrick's Missionary Society, founded in Ireland in 1932, had been entrusted with Catholic evangelisation in the districts of Calabar and Ogoja in Eastern Nigeria. The society is based in Kiltegan, Co. Wicklow, giving rise to the common appellation by which they are known.

55 Perhaps tellingly, between 1945 and 1950, when it was decided by the MMMs that such work was incompatible with the aims of the order, three MMM Sisters were in charge of the house-keeping in Kiltegan. See Thomas Kiggins, *Maynooth Mission to Africa: the Story of St. Patrick's, Kiltegan* (Dublin, 1991), pp. 184-85 for more on this episode.

mediated both by colonialism and by Catholic mission, and by extension, is it meaningful to characterise transpositions of scenarios in welfare politics between Ireland and Nigeria? and; (iii) is there anything in the nature of the Catholic missionary engagement with leprosy control in Ogoja which challenges popular preconceptions about Catholicism and Catholic mission? In order to suggest ways in which these questions can be refined and answered, it is necessary now to turn to a consideration of the historical entity known as Ogoja Province.

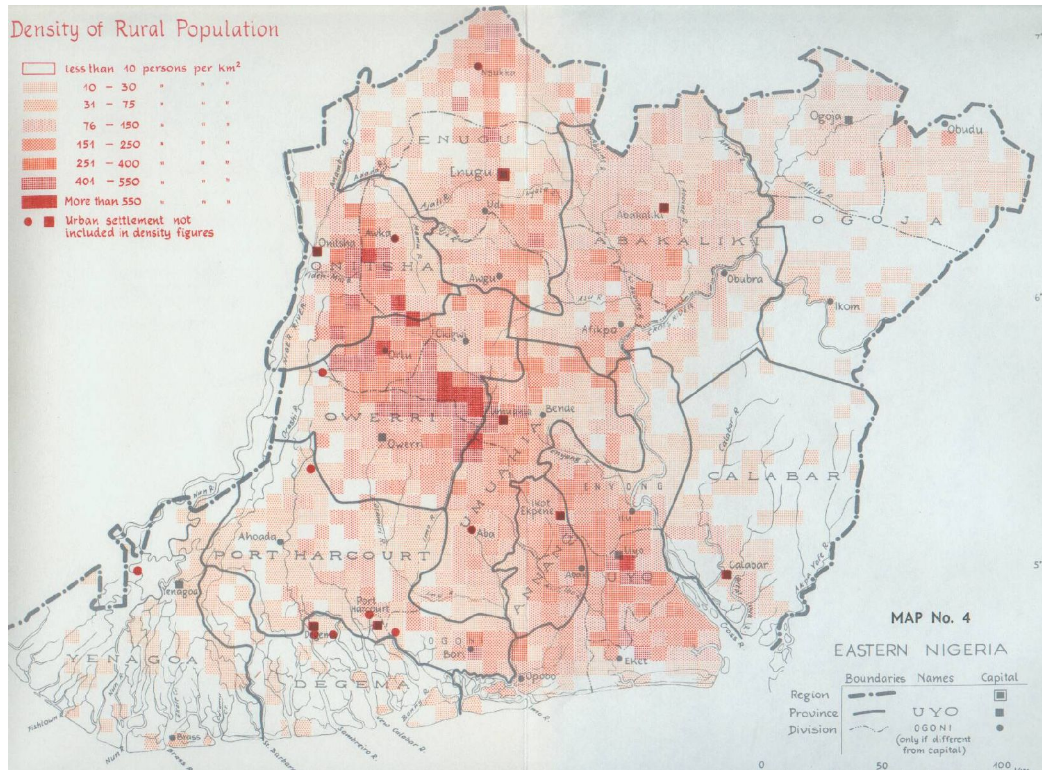
The historiography of Ogoja in its colonial and Nigerian context

i) population, language, trade, and migration in the Ogoja hinterland

The notion that the colonial entity administered as Ogoja Province represented a Nigerian form of 'the frontier' persisted right through the period of British rule in Nigeria. In a late colonial geography, Ogoja and eastern Calabar are referred to as the 'pioneer fringe',[56] Marginalised, by the economic geography of colonialism, as a result of its relatively low population density in contrast to much of southeastern Nigeria, and by virtue of its terrain, crossed by unforded rivers and characterised by heavy, clayey soils which restricted wet-season travel, it could still be characterised in the 1940s as a 'traceless praierie [sic]', by one of its most seasoned European observers, and as 'the Lost Province' in common colonial parlance.[57] Scholarly exploration has done little to address this marginalisation, a fact both pivotal in the administration and development of Ogoja Province, and restrictive of attempts to understand and describe these administrative processes. The dynamics of community, trade and migration in Ogoja, and the systematic misunderstandings to which these dynamics were subject, both constitute historical processes which call for scrutiny, and help shape development and welfare projects undertaken in the later colonial period and in post-independence Nigeria. An understanding of both, then, is crucial in the study of RCM

[56] K.M. Buchanan and J.C. Pugh, *Land and People in Nigeria: the Human Geography of Nigeria and its Environmental Background*, (London, 1955), p. 93.
[57] T. McGettrick, *Memoirs of Bishop T. McGettrick*, (Sligo, 1988), p. 126.

leprosy control in Ogoja Province since 1945.



Map 2: Population density in Eastern Nigeria (1953 Census)[58]

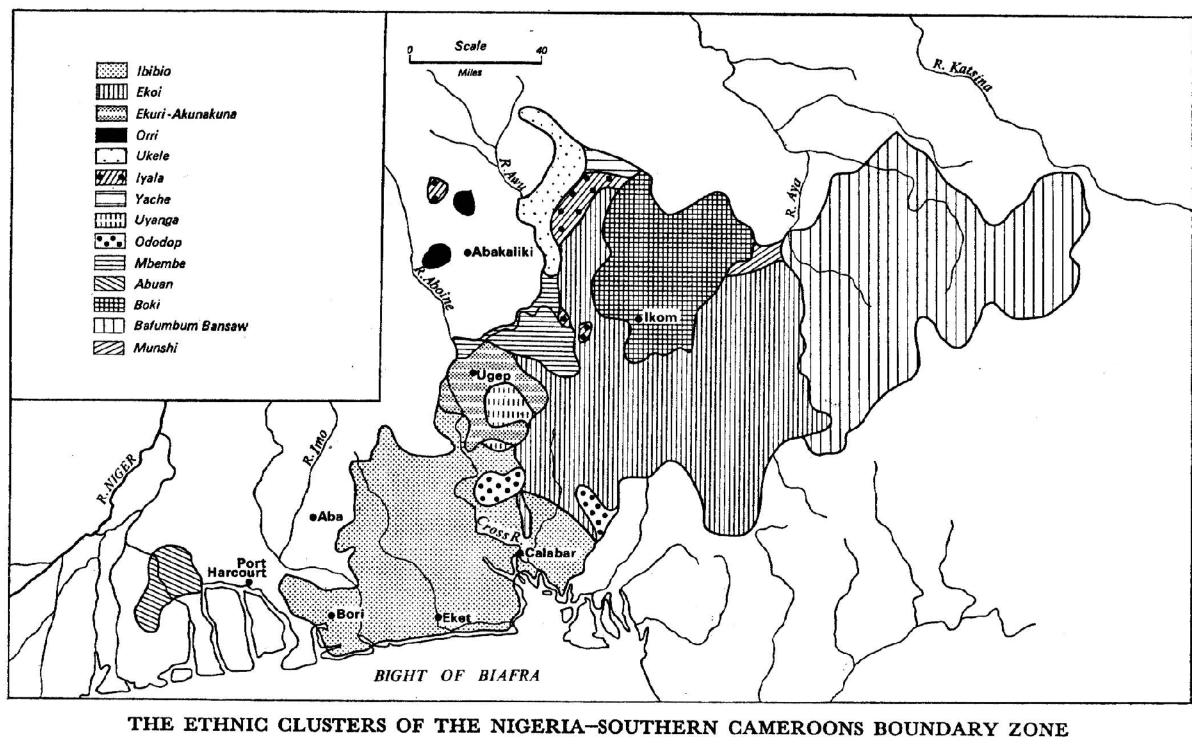
This section aims to discern the outlines and construction of anthropological knowledge on the Upper Cross River basin which included the area administered as Ogoja Province, the deployment of this knowledge in processes of colonial rule, and the operative significance of anthropological ignorance in determining the structure of European interactions with communities in colonial Ogoja Province. In the absence of a satisfactory history of colonial Ogoja Province,[59] itself perhaps an unsuitable construction through which to examine pre- and post-colonial historical patterns, let alone the complex dynamics of colonial interactions between Africans and Europeans, I will attempt to reconstruct a demographic and economic history of the pre-colonial and early-colonial Upper Cross River basin area, interspersing this

[58] Y. Karmon, *A Geography of Settlement in Eastern Nigeria*, (Jerusalem, 1966), between pp. 44-45.

[59] E.O. Erim, *Idoma Nationality 1600-1900: Problems in Studying the Origins and Development of Ethnicity,* (Enugu, 1981), S.O. Onor, *The Ejagham Nation in the Cross River Region of Nigeria,* (Ibadan, 1994), and M.B. Abasiattai, ed., *Akwa Ibom and Cross River States: The Land, the People and Their Culture,* (Calabar, 1987) constitute partial coverage of this history, but each work presents an incomplete articulation of the inter-group relations which figure in the demographic, social and economic history of the area.

with an examination of systematic misconceptions running through twentieth-century scholarly presentations on the population of this area of Nigeria.

Much of the published material which deals peripherally with Ogoja writes of the area as characterised by an ethnic and linguistic complexity, without attempting to address the historical roots or conceptual salience of this determination. Mapping fourteen non-Igbo ethnic clusters inhabiting the Cross River basin, Anene writes of the difficulty of distinguishing Bantu from Semi-Bantu[60] language speakers.

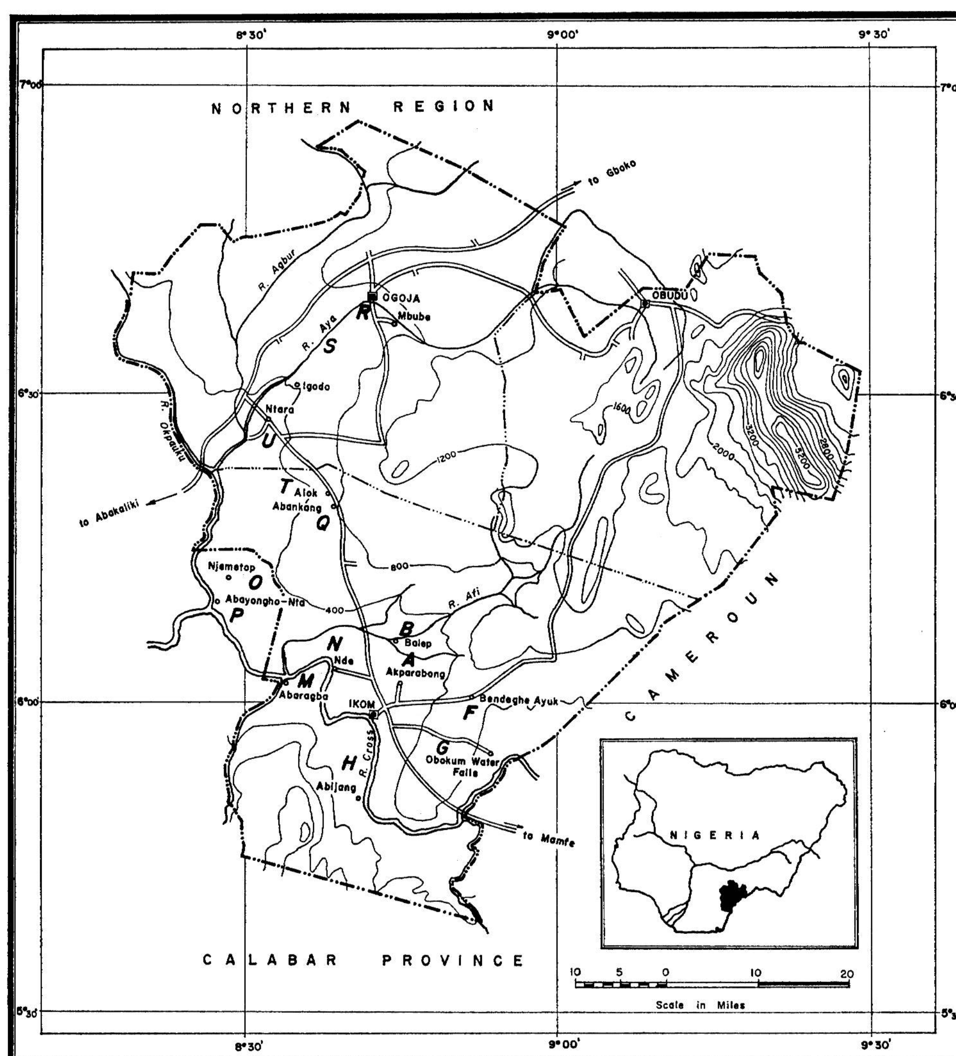


Map 3: Ethnic diversity in Ogoja and surrounding areas[61]

[60] J.C. Anene, *The International Boundaries of Nigeria: the Framework of an Emergent African Nation*, (London, 1970), pp. 53-57. Bantu and Semi-Bantu were among the broad linguistic-ethnic descriptors used to group and distinguish populations in the Cross River basin and Cameroons grasslands - while early classifications group most Upper Cross River basin communities as Semi-Bantu, D.W. Crabb, *Ekoid Bantu Languages of Ogoja, Eastern Nigeria: Part 1: Introduction, Phonology and Comparative Vocabulary*, (Cambridge, 1965), following Greenberg, classes 14 cognate languages as 'Ekoid Bantu'.

[61] Anene (1970), p. 54.

MAP OF OGOJA PROVINCE SHOWING THE DISTRIBUTION OF THE EKOID BANTU LANGUAGES OF OGOJA



SOURCE OF BASE MAP:
Survey Department, Nigeria.
SOURCE OF DATA:
Prof. David Crabb, Princeton University.

DRAWN BY:
Simeo B. Siamo
Rutgers University.

Map 4: Ekoi/Ejagham-speaking communities in Ogoja Province[62]

Crabb notes that one broad population group consisting of 14 geographically dispersed speech communities was interspersed in colonial Ogoja Province among a total, conservatively estimated, of 50 separate language communities.[63]

[62] From Crabb (1965), p. 4. Correlating with Anene's map, it will be noted that most of these 'Ekoi' villages fall within the boundaries of what is shaded as Boki, in evidence of the interpenetration which so baffled senior colonial observers and administrators.

[63] Crabb (1965), p. 5.

At the root of many of the depictions of demographic complexity in this area of Nigeria rests the work of P. Amaury Talbot, an early British political agent in Southern Nigeria, whose 1926 work, *The Peoples of Southern Nigeria*, was among the first systematic attempts to reconstruct a history of the societies inhabiting the area of colonial Ogoja Province. Remarking on the abundant remains of what he named as 'dolmens' and 'menhirs', as well as on mine-workings, of which no local tradition was said to exist, Talbot postulated firstly an ancient Semi-Bantu occupation of the area, and an ingress of ancient or medieval Egyptian culture which accounted for the evidence of mining.[64] In order to explicate the contemporary patterning of languages and communities in the region, Talbot mooted a 10th-11th century Igbo invasion of the western section of the Province (comprising the colonial divisions of Abakaliki and Afikpo), which overwhelmed and drove eastward all but a few isolated Semi-Bantu groups.

This account has been alternately embroidered and rejected by subsequent scholars, and has seeded much of the discourse on southeastern Nigeria current among anthropologists and administrators during the colonial period. The assumption drawn from early missionary impressions that adjacent groups in the area lived in warlike isolation, tempered by occasional trade relations,[65] proved difficult to dispel from the scholarly literature. Talbot enumerates a profusion of tribal, sub-tribe and clan groups, ranging in size from 73 persons to 31,113, and interpenetrating in an historical pattern of migration of almost indiscernible complexity. Recent scholarly accounts of Ogoja history, attempting to abstract patterns of commonality and 'nationhood' from among the seeming profusion outlined by Talbot, have bemoaned the popularisation of lazy demographic assumptions consonant with the earliest examinations of the history of the Upper Cross River basin.[66] Indeed, writers such as S.O. Onor contrast accounts such as Anene's, which subjugates notions of ethnicity to the solution of a problem in international politics, to portraits which postulate internal dynamics to change in Ogoja, and attempt to texture an approach to the history of Ogoja by charting a

[64] P.A. Talbot, *The Peoples of Southern Nigeria: A Sketch of Their History, Ethnology and Languages, with an Abstract of the 1921 Census*, (Oxford, 1926), Vol. I, p. 226.

[65] Talbot (1926), Vol. I, pp. 227-28, quoting Rev. Goldie of the United Free Church, c. 1884.

[66] S.O. Onor, *The Ejagham Nation in the Cross River Region of Nigeria*, (Ibadan, 1994), p. 7.

series of inter-related, closely explicated migrations to the north and the south which transcend simple association with colonial Ogoja Province.[67]

In his foreword to Onor's book on the Ejagham[68] nation, Charles Effiong writes that 'beyond the seeming distinctiveness of Cross River peoples, lies a corpus of factors that dramatise their immense relatedness'.[69] Onor discerns and develops patterns which link both the Ejagham (formerly Ekoi) speaking groups in the colonial provinces of Calabar and Ogoja, the eastern parts of which now comprise Cross River State, with one another, and with, among others, their Boki, Yala, Mbembe and Ukelle[70] neighbours. Determining an intricate relationship between essentially agrarian cultures and the variable and diverse economic opportunities offered by different geological and ecological zones within the broader Cross River area, Onor draws attention to 'shared historical experiences through common routes of migration and settlement points...[leading to] a number of common cultural institutions and belief systems'.[71] Quoting Andah on evidence of multi-lingualism in parts of the region, taken to reflect a greater cultural and socio-political homogeneity than the linguistic/ethnic diversity of the population might suggest, Onor goes on to suggest that 'interaction over time through commercial relations, inter-marriages and warfare, gave rise to mutual exchanges of socio-cultural values and institutions, thereby fostering and expanding the bases for common consciousness'.[72]

The extent and salience of these interactions is outlined in a series of chapters on the migration patterns and economic activities of the Ejagham, and on their relations with non-Ejagham neighbours. Citing population pressures in the Nta/Nnam forest complex and the contiguous area of Ebanembim, in the Ikom area in present-day Cross River State, Nigeria, and Nsan-Araghati area in present-day Cameroon, where Ejagham populations had

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67 ibid.

68 The usage 'Ejagham' is preferred by Onor to 'Ekoi', a term deriving from Efik languages spoken in the Calabar area to the south of colonial Ogoja Province. It should be noted that the groups classified by Onor under this heading mirror those enumerated by Crabb in his study of Ekoid Bantu languages in Ogoja.

69 Onor (1994), p. 6.

70 These names represent larger language groups rather than clans, and are in this way similar to the designation 'Ejagham.

71 Onor (1994), p. 144.

72 Onor (1994), pp. 144-45.

ostensibly been gathered by 1600AD, Onor traces distinct series of short- and long-distance migrations of small groups of Ejagham. Commenting on the Ishibori migration from Nkim Ntal to their current location in the present-day Ogoja town complex,[73] a migration which is especially pertinent in the early development of RCM leprosy control in northern Ogoja Province, Onor lists the quest for fertile agricultural lands, the urge to own salt ponds, and the agro-commercial benefits offered by proximity to navigable rivers as among the typical motivations for migration.[74] Agricultural and household organisation were predicated on yam and ancillary crop cultivation, access to river and forest products, and the availability of opportunities for craft and salt production. The variegated pattern of opportunity served as a spur to trade in the area. In this respect, the example given by Onor of trade between the pottery producers of Nsofang and Abijang village-groups, where suitable clay deposits were in abundance, and the salt producers of Abia village-group epitomises the trade-related interactions linking Ejagham groups.[75]

In his Ejagham-focused portrait, Onor seems to underestimate the significance of neighbouring groups in evolving some of the patterns which link and distinguish communities in the Upper Cross River basin. Typecasting the Yala as easily displaced by migrating Ejagham groups in search of resource-maximising opportunities glosses over the role of Yala groups in constructing trade relations with their Idoma ethnic confreres to the north, resulting in trade in salt, fish and red pepper which dispersed these products throughout the Ogoja area.[76] While willing to accept the multi-lingual interactions of adjacent Boki, Yache, Yala, Mbembe, Ukelle and Ejagham groups, and the cognate status of dispersed Ejagham languages, the portrait of agricultural and economic innovation in the Upper Cross River basin offered by Onor seems hidebound into stasis by his focus on problems of ethnic nationality, resulting in a somewhat attenuated and unsatisfactory counterpoint to the anthropological misconceptions he wishes to displace.

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[73] Ogoja Convent Files. An account of the history of the Medical Missionaries of Mary in Ogoja, written in 1986, notes that latter-day Ogoja is a group of merged villages, namely Igoli, Ogboja, Abakpa, Ishibori and Moniaya. Moniaya is the site of the RCM Ogoja Leprosy Settlement.

[74] Onor (1994), pp. 76-78.

[75] Onor (1994), pp. 130-31.

[76] E.O. Erim, *Idoma Nationality 1600-1900: Problems in Studying the Origins and Development of Ethnicity*, (Enugu, 1981), p. 121.

Rosemary Harris adds a sense of spatial dynamism to this portrait of cross-regional trade in her description of the history of trade at Ikom, outlining how the relation of Ikom to its hinterland mirrors that of Calabar to the Cross River region as a whole, with less formally evolved but nonetheless functionally similar trading families exerting strategic control over the trade of certain products at the confluence of a variety of trade routes.[77] Adducing a long pre-colonial history of trade from the culturally-embedded presence of nineteenth-century luxury items as status goods in the area,[78] Harris goes on to tease out the salience and changing relative value, through the late nineteenth and early twentieth centuries, of various trade goods in the Ikom hinterland, and the negotiation of various routes amid the calculus of need and surplus along navigable avenues through the surrounding forest and grassland areas.

Dating the development of Ikom as a relatively egalitarian trade-based society from five or so loosely confederated villages in the early nineteenth century,[79] Harris notes that Ikom's strategic location on easily navigable river and overland routes from Calabar (allowing Efik traders from Calabar to alternate routes depending on the amenability or hostility of intermediary groups), and its early orientation to the facilitation of trade allowed traders from Ikom to control the vital route from slave-raiding areas in Mamfe and Bamenda (in the present-day Cameroon grasslands), and a number of Cross River tributary routes northward to Bansara and Ogoja, and hence to the Benue Plateau beyond colonial Ogoja Province to the north.

The organisation and development of this trade depended crucially on controlling the availability of forestry goods and labour in the Ikom region, with the felling of trees tall enough for canoes, and the manufacture of these canoes being of central importance. Suitability of trees was determined by size and by proximity to water, given that the canoe

[77] Rosemary Harris, 'The history of trade at Ikom, Eastern Nigeria', in *Africa*, 42, 2 (1972), pp. 122-39.
[78] Harris (1972), pp. 124-25.
[79] Harris (1972), p. 124 lists Okuni, Adijikpor, Akparabang, Nsofang and Little Obokum as the generally accepted constituent villages in this confederation, and notes that the chiefs of these villages made reciprocal visits on the occasion of funerals or installations of chiefs, sharing equal portions of meat, a fact of some significance given the status invested in certain portions.

would be 70 to 80 feet long, and during the nineteenth and early twentieth centuries, by which time the lower Cross River nearer to Calabar had been exhausted of such trees, the tributaries of the Cross River to the north, in Boki areas of colonial Ogoja Province, provided ample supplies for local and down-river traders.[80]

A useful indicator of the sophistication and diversity of the trading economy in Ikom was the opportunity afforded to hard-working and ambitious young men to hire or buy canoes on credit, secured against future profit from riverine trade, while engaged in service to wealthy traders.[81] As in much of south-eastern Nigeria, palm kernels were among the most important commodity transported by Ikom traders, for which tobacco, kerosene, salt and gin were traded northwards as far as the Obudu plateau, via Bansara and Ogoja, despite the risks involved in transporting goods along the precipitous route from Ogoja to Obudu.[82] While Harris asserts that trade in slaves from the Ogoja area was of minor significance in the Ikom trade network,[83] both Onor and E.O. Erim contest this notion. Onor postulates links between Ejagham trade and 'the vast "slave lands" of the Benue/Plateau area' to the north,[84] while Erim suggests a 'brisk trade [in] slaves... between ancient Kwarafara and Calabar', linking Idoma trade and migration into the Ogoja area from the north to the development of such a trade.[85]

The labour factor in Ikom trade seems to have been quite complex. While the Ogoja area was bounded on the north and east by the slaving areas of the Benue basin and Bamenda plains respectively, the means of transit of slaves to the coast was unclear. Evidence suggests that the trade in slaves was viewed differently to other expeditions and exchanges. Kinship patterns in the Ogoja hinterland of Ikom had a defensive effect against the alienation of kin for pawning or slaving, with the combination of matrilineal jural authority and patrilocal residence common in the area requiring the assent of both kin groups to pledge or sell a

[80] Harris (1972), pp. 129-30.
[81] Harris (1972), pp. 133-34 recounts the career of one such trader called Okim Ofu, who worked from 1912 at Bansara, and was able to engage in trade on his own behalf from 1915, having shared in the hiring of a canoe in the meantime.
[82] Harris (1972), pp. 133-35.
[83] Harris (1972), p. 135.
[84] Onor (1994), p. 133.
[85] Erim (1981), p. 121.

kinsman. As a result, a personal debt would often be settled by the debtor pledging himself.[86]

The small and rather uniform size of political groupings in the Ogoja and Ikom areas militated against systematic raiding of neighbours for the purpose of slaving, a process which had developed to the north and east of the area. Some of the barriers posed by kin and village-group politics were overcome through participation in the slave trade between Bamenda and Calabar. The mechanics of this trade, drawing on unpaid kin labour as carriers on the assumption that slaves brought benefits to the entire kin group, often resulted in the integration of slaves into Ikom kin groups. Since this integrative process brought control over offspring from marriage to a slave, and over labour to the slave owner, and thus increased the number of dependants a trader might have, it was rare for slaves to be sold on immediately, despite the profit which could be made in this way.[87] The importance of yams as a tradable good downriver led to the establishment of yam plantations around Ikom, a process which also crucially relied on slave labour.

Harris substantiates her account of a robust and sophisticated trading system centred on Ikom with a convincing description of the percolation of stable currency and exchange values throughout this system. In contrast to much of the Lower Cross River trading area, the brass rod was not widely used in the Ikom networks, apart from instances of exchange with downriver traders where neither yams nor other trade goods were available or sought, and in the unique instance of trade with Obudu plateau traders, where the difficult route used, involving head-loaded porterage, introduced an unquantifiable factor of perishability into the trade equation.[88] In its stead, a combination of tobacco-leaf, for small transactions, palm-wine, for the purposes of negotiation and facilitation along trade routes, and a cloth known as Florentine check, which had a stable value of five shillings per ten-yard length in the first decades of the twentieth century, were used to establish 'normal', comparable exchange, labour and service values across the trade network.[89]

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[86] Harris (1972), p. 127. My use of masculine gender terms reflects Harris' own - there is no distinct reference made in the article to the engagement of women in trade or credit patterns.
[87] Harris (1972), p. 131.
[88] Harris (1972), pp. 135-37.
[89] Harris (1972), pp. 131, 133, 135-38.

The overall impression communicated by the unfortunately rather limited series of scholarly considerations of the people, places and politics of the pre- and early-colonial area later known as Ogoja Province is of a complex interlacing of language groups, agricultural, mining, and manufacturing communities, trade networks, and systems of economic value, with far-reaching links to communities beyond the borders of the colonial province. The refinements brought to bear on the evidence which can be recovered from the pre-colonial record are largely a post-colonial phenomenon; analytical techniques were never applied in so refined or nuanced a fashion to colonial administration in Ogoja, and it is to the assembly of information about the population of Ogoja and environs, and its construction and deployment as knowledge by administrators that I turn to next.

ii) Ogoja - colonial commentary

The intricacies of pre-colonial social and economic organisation in the Cross River region distinguished by scholars such as Onor, Erim and Harris can be contrasted with the seemingly continual and successive misapprehension of these patterns in the political and epistemological vacuum of conquest, pacification and reorganisation. The narrowing of horizons of rule consequent on the violent, conquest driven pacification of Ogoja Province[90] can be distinguished in the work of two of Britain's leading commentators on the politics of British colonial administration in Africa, Margery Perham and Lord Hailey.

The history of British colonial Eastern Nigeria is punctuated by a sequence of political reorganisations, each conducted with the aim of superseding the problems generated by its predecessor, and with the hope of making European legislative and executive armoury cleave more closely to a sense of what characterised legitimate exercise of authority in African polities. The roots of the twentieth-century European presence in Nigeria in processes of conquest and pacification were held by colonial commentators to be of continuing salience in the acceptability and reception of British rule, and in the tense and purposefully measured

[90] Talbot (1926), pp. 228-30.

nature of the dialogue between constitutional necessity and political reality.

In the absence of clear signals regarding which perturbations on the political terrain were likely to result in systemic instability, an absence resulting in large part from the continually limited horizons of European interactions with eastern Nigerian communities in all their diversity, complexity and insufficiently-fathomed relatedness, there emerged a set of techniques and discourses of 'indirect' rule which only served to emphasise the dichotomy between the political perceptions and desires of rulers and ruled in the region. The brevity of the period of colonial rule, its evocation of a self-validating discourse of what Nigeria had been and could be, and the rapid cycling of unsuitable administrative approaches to snowballing political problems epitomised the shortcomings in British theories of statecraft in Eastern Nigeria.

This systematic misapprehension can be detected in the work of Margery Perham on native administration in Nigeria, a volume shot through with evocative references to the repellent strangeness, pathological resistance to the benefits of overrule, and frustrating heterogeneity of eastern Nigeria as a political entity and social tapestry. Commenting on the early engagement of the colonial state with southeastern Nigeria, as distinct from the southwest and the north, Perham writes:

> the sense of revulsion from the natives felt by Europeans has probably been more extreme here than in any other part of British Africa, and is a fact very relevant to the history of administration.[91]

Added to this revulsion were the aggravations of ill-health, monotonous forest views, and enervating climatic conditions, all of which contributed to the problematic 'psychology of administration' in the area.

Following a flawed amalgamation of the area into the Lugardian model of a Nigerian Protectorate in 1914, the failure of colonial rule in eastern Nigeria to 'produce the expected improvements'[92] in the light of Perham's contention that the 'political education of the people [is the Government's] main object',[93] is read as a pathology of strategies and systems of rule,

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[91] M. Perham, *Native Administration in Nigeria*, (London: Oxford University Press, 1937), p. 22.
[92] Perham (1937), p. 201.
[93] Perham (1937), p. 345.

rather than of the nature of this rule itself. In this argument, there is an iterative revelation, by means of the processes of 'investigation and reform', of the 'real situation' in Nigerian society with which imperial rule can harmonise, eliciting from Nigerian systems of authority the political strategies appropriate to the development of a united Nigerian polity.[94] Following this characterisation, which assumes the implicit priority of the 'state political' over issues of economics, trade and conquest, systemic flaws are attributed to misidentification of authority figures or the extent of the writ of such authority, while the changing social and economic circumstances in which authority is being contested are viewed as secondary phenomena.

The signal crisis from which Perham's portrait derives its diagnostic and prescriptive authority is the women's movement centred around the Aba riots of 1929, often referred to by contemporary scholars as the Women's War.[95] Employing recourse to political resources and symbols whose meaning was largely opaque to European commentators and administrators, Igbo women across a broad swathe of southeastern Nigeria demonstrated their purportedly unschooled resistance to the impositions of the Warrant Chief system of native courts, and the implication of this system in tax collecting and census organisation. Characterising local information networks as rumour-driven and corrosive of the exercise of authority, and local political expression as typical of an apocalyptically-hued pathological African reaction to the stresses of the 'strong, all-embracing pressure of European influence',[96] Perham abstracts the lesson that:

> People who do not know how to communicate or even to formulate their sense of grievance in constitutional terms may resort to violence as the only effective way in which they can show their dissatisfaction with their conditions.[97]

The valorising of indirect rule, amid the political chaos of imposed direct rule according to the post-pacification settlement, and the epistemological chaos of the 'very dark and difficult

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94 Perham (1937), p. 201.

95 The term 'Women's War' is a translation of *Ogu Umunwanyi*, and is the term by which many scholars of Eastern Nigerian history now refer to the Aba riots of 1929. See T. Falola, 'Introduction', p. 4, S. Ottenberg 'A history of the studies of culture and social life in Southeastern Nigeria', pp. 57, 72 n. 149, and O. Onwumere, 'Transitions in the political system of Igboland: the Warrant Chief system, 1900-1929', pp. 177-79, all in T. Falola, ed., *Nigeria in the Twentieth Century*, (Durham, NC, 2002). For a more in-depth review of the political processes leading up to the Women's War, refer to A.E. Afigbo, (1972).

96 Perham (1937), p. 218

97 Perham (1937), p. 206.

anthropological country'[98] presented by southeastern Nigeria, shaped what was in essence a dual retreat from the acknowledgement of African political difficulties with European rule. In effect, the very category of 'political education' created its own class of miscreants, idlers and troublemakers to be reproached, upbraided and marshalled, while at the same time, efforts to discern the patterns and categories of local resistance from amid the disordered corpus of reports on law, religion and social and political structure[99] foundered 'on the edge of a wilderness of heterogeneity through which few tracks present themselves.'[100] Faced with this self-imposed elicitation of complexity, even the most ostensibly consultative of government processes were subject to misconception and maladministration, a point well outlined by Simon Ottenberg with reference to endemic corruption and ineffective governance among Native Authorities by the late 1940s.[101]

Focusing on the desirability of building a 'sound united state' in Nigeria, Perham conceives such a state as potentially under assault from the unmanaged fruits of education and urbanisation.[102] A somewhat less polemical and more finely-grained examination of the conditions of local government in Nigeria is provided in a pair of reports made by Lord Hailey, based on research carried out in the early 1940s, and again in 1947 and 1948. Assenting to the recommendations emerging from the process of constitutional revision in post-1945 Nigeria, which would rationalise the Native Authority structure in Eastern Nigeria under a series of county and district councils, Hailey outlined the difficulties of the existing system of Native Authorities, some ten to fifteen years after the changes which Perham had assessed in her earlier work. Hailey's reports continued the attempt to mediate between the responsiveness, and the manageability, of government structures. In many ways, given their influence in guiding the political accommodations made manifest in localities across Nigeria,

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98 Perham (1939), p. 222.

99 Ottenberg (2002), pp. 44-45. Ottenberg's presentation outlines the close association between political agents such as Talbot, official anthropologists such as C.K. Meek, academic anthropologists, and colonial administrators in developing a corpus of anthropologically-sanctioned knowledge as an aid to exercising political authority in southeastern Nigeria. The relegation of much significant material to appendices in intelligence reports is indicative of their predominantly practical focus, as well as of their theoretical shortcomings as a basis for understanding the dynamics of change and of grievance in African communities under colonial rule.

100 Perham (1937), p. 227.

101 Ottenberg (2002), p. 45.

102 Perham (1937), ch. XXI. The quoted phrase is on p. 363.

his reports simply helped perpetuate the problems of colonial government in dealing with complex indigenous political structures and demographic patterns.

Part of this perpetuation stems from continued obeisance to the corpus and techniques of administrative knowledge generated in the wake of earlier political disturbances. Noting the effort to regularise colonial administration in Eastern Nigeria after the Women's War of 1929, Hailey drew attention to 'the preparation of over 300 special studies into the nature of the indigenous authorities' across the eastern region.[103] Though these special studies or 'intelligence reports' were conceived and carried out using analytical categories drawn from contemporary anthropology, and with the aim of stabilising colonial rule in the region,[104] the resulting institutions had, even by the early to mid 1940s, met with less success among Igbo and upper Cross River groups than in coastal areas, Hailey maintaining that village councils remained 'largely experimental' in terms of their status and efficacy in the former areas.[105]

Indeed, from the point of view of the colonial government, the complexity of administering political control of Ogoja Province, which had not even registered in Perham's portrait, was rendered more acute by the apparently diverse patterns of traditional organisation, the scattered settlement and inaccessible terrain, and the existence of 'many tribal fragments and... numerous languages'.[106] Hailey draws specific attention to the conflict between largely unsuccessful village councils, constructed according to government policy, and local priest-chiefs, whose mobility and activity seemed to have been restricted by a series of protective measures assumed to maintain links between family groups and religious observance, but whose power and authority nonetheless held sway over many issues of immediate local significance.[107]

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[103] Lord Hailey, *Native Administration and Political Development in British Tropical Africa, 1940-42*, (Liechtenstein, 1979), p. 147. For a discussion of Hailey's travels in West Africa, and of the milieu in which his African work was carried out, see J.W. Cell, *Hailey: a study in British Imperialism, 1872-1969*, (Cambridge, 1992).

[104] Ottenberg (2002), p. 45.

[105] Hailey (1979), p. 148.

[106] Hailey (1979), p. 151.

[107] Hailey (1979), pp. 150-51. The terms 'tabu' and 'juju' are used in Hailey's text, subsuming a variety of local institutions surrounding totems, age-set organisation, and masquerade- and dance-societies, many of which had broad political currency across the Cross River basin. This rather blunt shorthand aside, Hailey recognised that the role of new village councils was often likely to be misconstrued given the pre-colonial focus of village meetings on issues of farming, land distribution and harvesting, and consequently

Using Ogoja Province as an exemplar of 'the great number and diversity of the institutions which it has been found necessary to recognise', he lists 44 clan councils, giving the example of three of these which have 21, 12 and 26 dependent sub-clan councils, noting the existence of an additional 14 independent sub-clan councils, 17 village group councils and 107 village councils.[108] In figures tabulated for a later report, Ogoja Province, estimated to make up 13% of the population of the Eastern Region, contained 20% of its native authorities at both full and subsidiary levels, with a diversity of institutional type unmatched elsewhere besides the Cameroons Province.[109] Despite the existence of Divisional and Provincial Meetings of these authorities, resistance to the idea that such meetings might form the basis for Divisional Native Authorities persisted, and consolidation seemed to Hailey to be difficult to achieve.[110] Further contributing to the diffuse nature of administrative function in Ogoja was the imprecision surrounding the very term 'Council': entering into common usage as a result of being drawn from Government Notifications, Hailey noted that the term 'applies in some cases to bodies which have a recognised constitution, but it more often connotes only amorphous bodies, with no determinate composition, and sometimes with no more formal constitution that a village "moot".'[111]

While Native Courts in Ogoja Province tried fewer civil and criminal cases than in any other Province in Eastern Nigeria, representing 8% of the total in 1947, over half of the Grade C, almost one fifth of the Grade D, and over a quarter of the Native Appeal Courts were located in the Province.[112] Exceeding in number even the recognised Native Authorities, the court

maintained that the system of governing communities in eastern Nigeria would require careful attention and slow evolution.

108 Hailey (1979), p. 149.

109 Lord Hailey, *Native Administrations in the British African Territories: part III. West Africa: Nigeria, Gold Coast, Sierra Leone, Gambia*, (London, 1951), pp. 147, 161. Figures and estimates are for 1947 and 1948. Among the types of Native Authority constituted in Ogoja are those represented by: Chief or titleholders in Council; District, Divisional, Federated or Federal Councils; Two or more Clan Village or Group Councils; Clan Councils; Councils [unspecified]; Group Councils; and, Village Group Councils.

110 Hailey (1951), p. 162.

111 Hailey (1951), p. 160.

112 Hailey (1951), pp. 175-76. Native Courts were graded A to D according to the Native Courts Ordinance No. 44 of 1933, with Grade A Courts empowered with full judicial powers, including capital powers, each subsequent grade having diminished capabilities. In the Eastern Region there were no Grade A Courts, 5 at Grade B (divided between Calabar and Onitsha), 54 at Grade C (of which 29 were in Ogoja Province), 492 at Grade D (with 93 in Ogoja), as well as 45 Native Appeals Courts, each also possessing status as courts of the first instance. Of these, 12 were in Ogoja Province.

system attempted in effect, if not in form, to replicate the indigenous juridical terrain, and the relative preponderance of higher grade courts seems to reflect the perceived independence and mutual mistrust ascribed by colonial anthropologists and administrators to the groups inhabiting Ogoja Province. Hailey clearly acknowledged the impracticability of supervising such a profusion of institutions, amid notionally impenetrable terrain, according to the prescripts of the Native Courts Ordinance.[113]

The relatively 'primitive' state of the organisational development of politics and finance in Ogoja Province had given rise by the early 1940s to a state of affairs where the proliferation of councils, courts and treasuries slowed administrative processes considerably, a situation exacerbated by the poor fit between political fragmentation and level of educational attainment among councillors, with many councils and treasuries vesting conduct of their affairs in district officers and clerks imported from Onitsha.[114] There was as yet no Finance Committee in Ogoja Province by 1948, and the preparation of estimates was still a matter for consultation between district officers and Native Authorities.[115] The twelve treasuries existing in Ogoja Province, reflecting a geographically uneven consolidation of the revenue collecting functions of the various Native Authorities, were relatively underfunded and continually subject to competitive pressures from the constitutive authorities.

In concert with local authorities across the Eastern Region, the various administrative tiers in Ogoja Province had been subject to the intense pressures of social, political and economic change in Nigeria during the 1930s and 1940s. While the pressures for constitutional change exerted by elite educated classes in urban Nigeria did not notably impact on local politics in Ogoja, the frustration indicated with the pace of service development was palpable in the area. The regionalisation of government in Nigeria into northern, western and eastern sectors, dating in essence from 1939, but formally mandated by the Richards Constitution of 1947, interpolated another set of administrative checks between central government and a local

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113 Hailey (1951), p. 172.

114 Hailey (1979), p. 149. Hailey mentions that the amalgamation of small units had progressed more quickly in Onitsha, which he seems to attribute to Onitsha being 'less primitive than Ogoja'.

115 Hailey (1951), p. 167.

government tier desirous of independence, while the salary regulations imposed on Native Authority employers in 1944 diminished their financial reach. The approval mechanisms of Public Works and Medical Departments were seen as a brake on the development of roads, dispensaries and medical services in the Province.[116]

The application of colonial power in Ogoja Province was never other than unsystematic. This is not to say that colonial administration was necessarily mystifying to African communities; more to the point, the unevenness of its application resulted in a variety of local anomalies, which effectively created a space for contestation and political competition between communities. Analysis of the political space created by the creation of leprosy control resources in Ogoja Province will substantiate this contention.

Anomalously, in the Nigerian context, the coming of colonial rule to Ogoja preceded the long-term missionary engagement. While the logic of colonial rule in such an area dictated that imperial agents, such as district officers, were in the best position to interpret indigenous responses to colonial structures to incoming missionaries, the poverty of anthropological and colonial intelligence reports on much of Ogoja Province reflected the shallowness of colonial structures and penetration in the area. Colonial officials struggled to understand the nuances of labour relations in Ogoja communities, and rarely attempted to co-ordinate the hodgepodge of structures of governance and administration across the province.

Yet from within this paradigm of rule, with all of its imperial anxieties and tensions between education and control, conquest and trusteeship, came a startling recognition of the sometime harsh and alien nature of medical authority in the colonial setting. Recognising the need to diverge from the educational function of government, Perham noted that:

> The Medical Department... is one that finds it most necessary to act directly without waiting to enlist the co-operation, still less the understanding, of the people. The measures necessary to deal with disease and especially of infectious outbreaks are often urgent. There is the continuous task of conducting hospitals in large centres according to standards that cannot... easily be diluted with the object of making them more comprehensible or of multiplying the service.[117]

This willingness to conceive of medicine in the tropics as a series of crisis narratives ties in

[116] Hailey (1951), pp. 10-11, 17-18, 183.
[117] Perham (1937), p. 295.

with assessments of biomedical interventions and public health measures elsewhere in Africa. The systematic insulation of medical departments from having to consider and understand the conditions of urban and rural life in colonial Africa gave rise to policies seemingly conceived in 'splendid isolation' from the populations whose health-related issues were addressed, a fact demonstrably underlined by the information networks through which public health contacts with African populations were evolved.[118] The construction of insensitive, paternalist plague control policies in Senegal, and the wilful blindness of public health officials to the socio-economic roots of tuberculosis in industrialising South Africa[119] are echoed, though less starkly, in the evolution of leprosy control, amid a gathering sense of crisis and gloom, in the circumstances of Ogoja Province in the 1940s.

From the foregoing, it will be clear that the development of a body of practical administrative knowledge and anthropological expertise about Ogoja Province was an incomplete and fragmentary process. The role of medical personnel in the administration of the province added little to the forms of knowledge seen as more paradigmatic of colonialism. Indeed the strategic role of medicine and public health in the project of governance was differently conceived from the political and administrative projects outlined by Perham and Hailey, or the education, development and general welfare projects proposed as part of post-war colonial development ideologies.

In the context of this background to pre-colonial history and political organisation in the area administered as Ogoja Province under British colonial rule, the accounts and comments of missionaries and administrators can be more adequately interpreted. Despite the paucity of testament from indigenes of the Ogoja area in the archival record, the interpretations of local behaviour and politics offered by Europeans resident in Ogoja and environs can be critiqued in terms of their tendency to misapprehend patterns, alliances and affiliations existing in the area, and thus, in terms of their unforeseen transformatory impact on local society. The

[118] See chapters five and six of thesis.

[119] M. Echenberg, *Black Death, White Medicine: Bubonic Plague and the Politics of Public Health in Colonial Senegal, 1914-1945*, (Oxford, 2002), pp. 261-62, and R. Packard, 'Industrialisation, rural poverty and tuberculosis in South Africa, 1850-1950', in S. Feierman and J.M. Janzen, eds., *The Social Basis of Health and Healing in Africa*, (Berkeley, 1992), p. 129.

language of making a viable provincial administrative structure, the development of which was a labour undertaken in common by missionaries, colonial officers and interested local parties, was forged by means of a variety of essentially political processes, of which the profound social and spatial transformations wrought by leprosy control was among the most significant.

iii) Colonial Nigeria and the history of administration in Ogoja

As noted previously, common memories of eighteenth century resource-motivated migrations have been traced among different groups in the north and the south of the Ogoja area. At the same time, the independence of villages and groups within the area necessitated a protracted campaign of village-by-village colonial military conquest, lasting from 1891 to 1909.[120] This extension of British colonial control in the Ogoja area was slow and took place remarkably late in the history of British imperialism. Talbot notes that missionaries from the Church of Scotland Mission (CSM) had reached Afikpo, near the Cross River, in 1883,[121] but that the northern areas of the province, namely Abakaliki, Ogoja, and northern Ikom Districts were not patrolled and 'pacified' until 1905-1914, after a succession of military expeditions and the slow extension of telegraphic communication throughout the Province.[122] Over the next generation, Ogoja and its hinterland registered little on the horizons of the colonial administration.

The preoccupations of colonial administrators with issues of land, ethnicity, and public order, demonstrated in the industrious response of political agents and anthropologists throughout the 1930s to the Women's War, and the policy reformulations foisted on local administrators and Nigerians alike by the successive governorships of Cameron and

[120] E.O. Erim, 'The old Ogoja Province under colonial rule', in Abasiattai, Monday B., *Akwa Ibom and Cross River States: the Land, the People and Their Culture*, (Calabar, 1987), pp.118-22, and P.A. Talbot, *The Peoples of Southern Nigeria*, (1926), outline the process of pacification and military conquest experienced in old Ogoja Province, north of the Cross River.

[121] Talbot (1926), vol. 1, p. 227.

[122] ibid., vol. 1, p. 230.

Bourdillon, and of Richards, Macpherson, and Robertson,[123] persisted in the aftermath of World War Two. The manner in which much of Government policy was formulated in Eastern Nigeria throughout the colonial era betrayed an official rationale most clearly concerned with understanding and managing Igbo demographic patterns and modes of political organisation.

A late nineteenth- and early twentieth-century population 'explosion' in the Igbo-speaking areas of Eastern Nigeria, to the west and south-west of Ogoja, and latterly encompassing Abakaliki, resulting from the ending of the trans-Atlantic slave trade and the Aro military expedition and associated patrols, and the subsequent 'pacification' of Igboland, in the early 1900s,[124] gave rise to fears about Igbo migration and containment. As a result of this, and of the political disturbances of the late 1920s, much academic and official attention was focused on exploring the dynamics of Igbo society, generating the classic anthropological enquiries of authors such as Daryll Forde, G.I. Jones, and C.K. Meek.[125]

Though Forde and Jones worked for a time on the fringes of Ogoja Province (around Ugep and Abakaliki respectively), neither focused specifically on the seeming ethnic melée of the eastern divisions of the province. Indeed, Jones' influential *Report of the Position, Status, and Influence of Chiefs and Natural Rulers in the Eastern Region of Nigeria*, commissioned by the Regional Government in 1956 to address calls for representation of chiefs in local and regional government, noted that 'the state of the roads compelled me to visit [Ikom] by water', and '[difficulties] of communication prevented my covering... Ogoja and Ikom districts so intensively',[126] his recommendations for the area amounting to a maintenance of

[123] Cameron (1931-1935), and Bourdillon (1935-1940, later Chairman of the Executive Committee of BELRA) differed on the extremity of response to the events of 1929, Bourdillon reversing many of Cameron's unworkable reforms of the early 1930s. The interim governorships of Shuckburgh and Burns in the early 1940s were unremarkable enough to be generally conflated with that of Bourdillon (see URL: http://www.worldstatesmen.org/Nigeria.htm – last consulted, 5th July, 2004, giving dates for these Governors, and compare with the list in *The Nigeria Handbook*, (Lagos, 1953), p. 296, which lists Bourdillon as occupant of the position to late 1943). Richards (1943-1947) and Macpherson (1947-1955, from 1954 as Governor-General) each have a Nigerian Constitution to their names, while Robertson, as Governor-General from 1955 to 1960, presided over Nigeria's Independence celebrations.

[124] This explanation is proposed by Karmon (1966), p. 41.

[125] For more on this corpus, see Ottenberg (2002).

[126] G.I. Jones, *Report of the Position, Status, and Influence of Chiefs and Natural Rulers in the Eastern Region of Nigeria*, (Enugu, 1956), p. i.

the *status quo ante* which saw Ogoja Province managed by Onitsha clerks, and a succession of struggling and widely dispersed European administrators.

This neglect did accompany the conferral on eastern Ogoja Province of the benefit of protection from substantial Igbo in-migration[127] - the finger-like expansion of Igbo groups radiating from Abakaliki across the west of the province throughout the first half of the twentieth century has been the subject of much intrigued comment,[128] and was viewed with suspicion and unease by missionaries and colonial administrators alike in the late 1940s and early 1950s. Indeed, the localised insecurity resulting from the contest for land and economic opportunity, centring around burgeoning rice production on the heavy soils of the area, prevented the opening of a government station at Abakaliki until 1948.[129]

From a constitutional perspective, post-1945 developments in colonial Nigeria were framed by the immediate dilemma of whether to

> [create] a modern Nigerian state with parliamentary institutions, or [to continue] development of the native authority system with the ultimate coördinating or cementing link left unspecified.[130]

The provocative, and rashly unconsultative, proposals of Governor Richards, involving a compromise between regional separatism and federalism, and enshrined in the 1945 'Richards Constitution', led to intense debate and dispute at all levels of society, vitiating the Nigerian response to economic development and political opportunity.

The instantly hostile response to the Richards Constitution was led by Nnamdi Azikiwe, a US-educated Igbo politician and journalist, and a leader of the National Council of Nigeria and the Cameroons (NCNC). Feeling that a fraudulent settlement had been perpetrated on the Nigerian people by a constitution which protected European hegemony over decision-making, the NCNC and other groups resisted and boycotted institutions set up under

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[127] J.S. Coleman, *Nigeria: Background to Nationalism*, (Berkeley, 1971), ch. 16, notes the colonial use of land regulations to support 'peripheral tribes' (p. 332) against land alienation to Igbo migrants.

[128] See Karmon (1966), p. 58, on the geography of this process, and G.I. Jones, 'Ecology and social structure among the north eastern Ibo', in *Africa*, 31, 2 (1961), pp. 117-34, on the social dynamics of this late and continuing migration.

[129] Karmon (1966), pp. 76-77.

[130] Coleman (1971), p. 273.

Richards' proposals.[131] The dilemma prompting the emergency response of the 1945 Constitution was left effectively unresolved at the arrival of Macpherson as Governor in 1948.

The example of Abakaliki demonstrates how economic opportunity and relatively unregulated access to agricultural resources combined to make an administrative area unmanageable from a colonial perspective. The co-articulation of reflections on land tenure, and attempts to resolve the political impasse confronting immediate post-1945 Nigeria, is neatly presented by Patrick Mbajekwe in an article on the ineffectual nature of land policy in colonial Nigeria. Remarking on the failure of extensive debate and interminable data collection to produce 'consistent and successful land policies',[132] he draws ironic attention to the vacuousness of L.T. Chubb's considered recommendations on Igbo land tenure that 'steps... should be taken to control changes which are occurring today as a result of both natural and artificial influences and to induce evolution on planned lines.'[133]

Following the arrival of Macpherson, who was determined to 'devote [his] special interest to the problems of local government',[134] provision was made for elected councils in the Eastern Region from 1950, the abolition of the post of Resident in 1956 and 1957, and the instigation of a federal system for regional self-government in 1956. The resultant dismantling of the often unpopular native authorities, seen as deriving their authority from British colonial power rather than from any basis in local politics,[135] broadened the political sphere open to educated Nigerians.

Even amid rapid reorganisation of local government, the complexity and variety of local institutions, as evidenced in Hailey's presentation, infinitely problematised the labours of the European political agent. The sensitivities prompted by novel opportunity and competition across and between neighbouring communities were managed, if at all, only through the

[131] Coleman (1971), ch.12.
[132] P. Mbajekwe, 'Debating land policy in colonial Nigeria', in T. Falola, (ed.), *Nigeria in the Twentieth Century*, (Durham, NC, 2002), p. 263.
[133] Mbajekwe (2002), p. 275.
[134] Coleman (1971), p. 314.
[135] Royal Institute of International Affairs, *Nigeria: the Political and Economic Background*, (1960), p. 67.

considerable leeway with which these agents could interpret policy and exhibit authority. In Ogoja Province, this impunity was even more salient than elsewhere. The political movement mounted by Iwong Morphy, founder, in 1953, and leader of the local branch of the Action Group in Ogoja,[136] seems to have made little impact on development politics in the area, and is perhaps more expressive of the acute consciousness of minority status[137] which led to the founding of the Calabar-Ogoja-Rivers Movement, calling for a separate non-Igbo region in Eastern Nigeria, and in which Ogoja politicians played only a minor role.

The failure of Ogoja to register in the broader Nigerian context, other than as an adjunct of a fractious anti-Igbo coalition, meant that as late as 1958, an official body such as the Willink Commission, convened to enquire into and allay the fears of minorities in the run-up to independence, writes in introducing the Eastern Region that 'little more need be said of Ogoja than that it is remote, poorly served by communications and, except for the two western Divisions, Abakaliki and Afikpo, divided into many small tribes'.[138] And Richard Sklar, presenting a portrait of the party political scene in Nigeria around 1960, and having documented an Ogoja case study, could still write of Ogoja that it 'presents a linguistic medley which is yet undocumented in its entirety'.[139]

In the post-1945 era, the most pressing administrative difficulties were mitigated by the gradual percolation of colonial welfare and development funding, provided under the heads of the Colonial Development and Welfare Act (1940). For much of Nigeria, development marched forward in loose obeisance to a rubric of 'agricultural productivity',[140] although a surprisingly large portion of government development expenditure was devoted to leprosy control, surpassed across Nigeria in 1947-48 only by building, roads, and rural water supply.[141]

[136] R.L. Sklar, *Nigerian Political Parties: Power in an Emergent African Nation*, (Princeton, 1963), pp. 468-71.
[137] Sklar (1963), p. 470.
[138] H. Willink, et al., *Nigeria: Report into the Commission Appointed to Enquire into the Fears of Minorities and the Means of Allaying Them*, (London, 1958), pp. 36-37.
[139] Sklar (1963), p. 13.
[140] T. Falola, *Development Planning and Decolonisation in Nigeria*, (Gainesville, FL, 1996), pp. 101-104.
[141] Falola (1996), p. 94.

The emphasis on leprosy was even more marked in Eastern Region estimates for the five year period 1951-56. Leprosy control swallowed upwards of 13% of total regional government development expenditure, rivalling the proportion spent on all other medical services, and on general education, as can be seen from the table below:

Table 5.4. Estimated expenditures, Eastern Region, 1951–1956 (£)

Schemes	*1951–52*	*1952–53*	*1953–54*	*1954–55*	*1955–56*
Agriculture	118,525	120,030	136,205	117,615	108,340
Building, staff, etc.	21,900	21,900	17,900	13,900	13,900
Community Development	50,000	50,000	50,000	50,000	50,000
Development Officers	21,020	21,020	21,020	21,020	23,520
Education, general	140,870	175,500	171,000	80,000	164,000
Education, technical	135,280	138,029	105,059	74,245	85,630
Fisheries	4,070	4,360	4,540	4,730	4,990
Forestry	29,941	31,032	30,046	26,425	27,150
Leprosy control	(147,656)	(147,656)	(147,656)	(147,656)	(147,656)
Medical and health	(151,746)	(151,746)	(151,746)	(151,746)	(151,746)
Roads	141,600	126,100	124,600	123,600	104,100
Social welfare	15,606	14,360	—	—	—
Telecommunications	35,700	56,300	94,800	51,200	62,000
Veterinary	19,451	14,277	13,036	12,957	13,233
Water supplies, rural	50,400	37,800	42,800	40,400	28,600
Water supplies, urban	59,200	66,300	63,300	40,300	20,900
Rice research	13,950	6,745	7,630	5,875	5,325
Total	1,156,915	1,183,155	1,181,338	961,669	1,011,090

Source: Nigeria, *Revised Plan.*
Notes: The grand total is £5,494,167; figures in parantheses are approximate.

Table 1: Estimates – Eastern Nigeria development expenditure[142]

Given that very little revenue was made available to Ogoja Province,[143] that the bulk of the funding for leprosy control was earmarked for the Nigeria Leprosy Service (NLS) schemes at Oji River (Onitsha Province), and Uzuakoli (Owerri Province), and that the RCM Ogoja Leprosy Scheme came to rival the NLS schemes in size and scope, it can be seen how massive an undertaking the RCM scheme was in the context of colonial Ogoja. On the unpredictable social and political terrain created by rapid change in late colonial Nigeria, the RCM Ogoja Leprosy Scheme was in a position to actively participate in shaping the new accommodation between Nigerians and expatriates, taking place at local, regional and national level across the country.

[142] Reproduced from Falola (1996), p. 108.
[143] See for example Ogoja Convent Files. Minutes of First Ogoja Provincial Staff Conference, 29-30th August, 1950, which explicitly bemoans this state of affairs.

Chapter Three - Exploring leprosy in the context of colonial control: Ogoja Province to 1945

In the last chapter, I demonstrated how misconceptions about the nature of society and politics in Ogoja Province, echoing and exacerbating typical shortcomings in early anthropological studies of southeastern Nigerian communities, were inscribed onto colonial administrative structures. In this chapter I trace the process through which such an administrative lexicon, compiled in the aftermath of the political crises in 1929 and 1930 across Eastern Nigeria, helped to stream emerging transformations in indirect rule into the development of settlement-based leprosy control. I demonstrate that the rhetoric of leprosy control was deployed in contradictory fashion by various colonial, medical and missionary parties to medical development in Ogoja Province, and piece together how broader developments in Nigerian leprosy control politics affected progress in Ogoja.

In describing early attempts to develop the kernel of a province-wide leprosy control scheme for the southeastern Nigerian province of Ogoja in the 1930s and early 1940s, this chapter demonstrates that there was no common understanding of what the centre of a large-scale leprosy control scheme should be, and that missions and colonial authorities differed considerably on who should be responsible for the running and financing of the resulting establishment. It also brings to light some of the local pressures and activities among groups of Africans attempting to deal with leprosy in Ogoja, and examines the ambiguous role played in local leprosy control politics by the first attempts to recommend and codify policy on leprosy control in the mid-1930s.

Leprosy in pre-colonial Ogoja and early colonial Nigeria

The variation across Ogoja Province in local approaches to leprosy remained as opaque to

early observers as the demographic and linguistic terrain. Though the approach to leprosy of certain communities in Ogoja was seen as cavalier, an intriguing document from 1895 reports the remark of an Ikom chief, referring to European visitors as 'those leprosy infested people who are addicted to speak through their nostrils'.[1] However, the construction of stigma with regard to leprosy is often taken to be a function of the impact of the same Christian missions which were eventually charged with alleviating the plight of leprosy sufferers in Nigeria. To see why this might be so, the way in which the relation between mission and leprosy came to be articulated in the colonial context must be examined.

Remarking on the Ghanaian case, K. David Patterson notes that '[leprosy], because of the fear and revulsion it evoked in Europeans, attracted much more attention than its public health importance or the possibilities for successful therapy could justify.'[2] The interest of Governor Hugh Clifford[3] in leprosy in Ghana, leading to attempts to assess its prevalence in 1913, was mirrored in Eastern Nigeria. In Ogoja, the earliest mention of leprosy dates from 1910 and 1911, when successive medical officers reported inconclusively and in contradictory fashion on the local incidence of the disease, in response to a proposal from Calabar that 'Leper Establishments' be set up in administrative districts. W. Stewart Snell, reporting in 1910, comments that '..there is a good deal of leprosy in this district… the native knows the disease'.[4] The following year, his replacement, A.W.H. Grant, reported that the disease was rare and that consequently a leprosy centre would not be needed.[5]

This portrait of the contradictions in the approach of early colonial administrators to leprosy tallies well with Brightmer's outline of how the structure of nineteenth-century interactions between Europeans and Africans, largely urban and trade-based, limited European contact with African leprosy sufferers. This fact, combined with leprosy's low mortality rate in

1 quoted in Erim, 'The old Ogoja Province under colonial rule', p. 119.

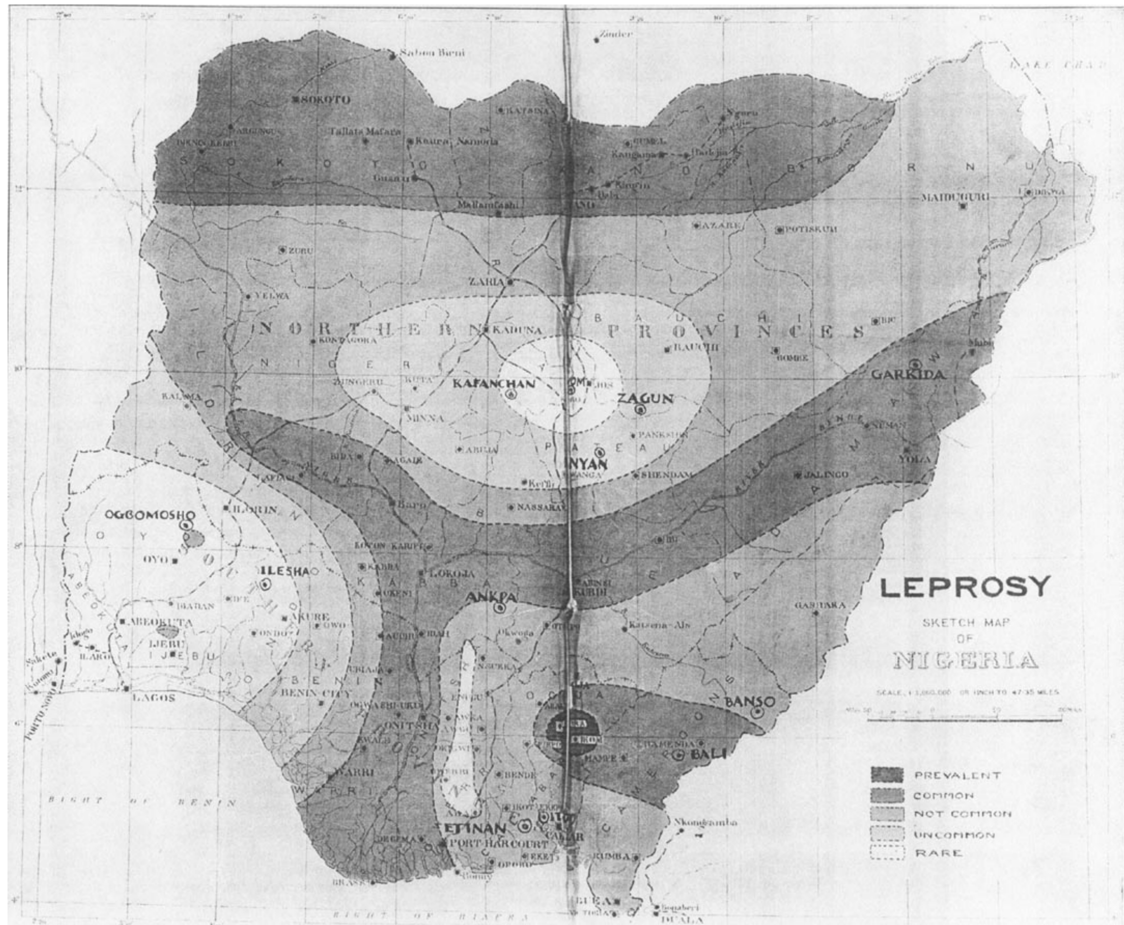
2 K.D. Patterson, *Health in Colonial Ghana: Disease, Medicine, and Socio-Economic Change, 1900-1955*, (Waltham, MA, 1981), p. 73.

3 Clifford, Governor of Ghana in 1913, was also Governor of Nigeria at a later stage, and was crucial in elaborating a new template for the future governance of Nigeria in the wake of Lord Lugard's impact on indirect means of administration, reflected in a famous address to the Nigerian Council in 1920.

4 National Archives, Enugu (NAE), CALPROF 14/5/40. Note dated 12th May 1910 from W. Stewart Snell, Medical Officer, Ogoja, to the District Commissioner, Ogoja.

5 NAE, CALPROF 14/5/40. Note dated 21st Jul 1911 from A.W.H. Grant, Medical Officer, Ogoja, to the District Commissioner, Ogoja.

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.'[6] This 'accidentally'[7] transformed leprosy into a disease with a different, religious character, as is borne out by the history of leprosy control in Ogoja.



Map 5: Relative prevalence of leprosy in Nigeria, 1932[8]

Regarding the prevalence[9] of leprosy in Nigeria as a whole, R.G. Cochrane, writing in 1928, outlines the results of early work undertaken by medical doctors working throughout the

6 M.I. Brightmer, 'The spatial pattern of leprosy on the Cross River region of Nigeria', (Ph.D., Liverpool, 1994), p. 65. The listed diseases are referred to by Brightmer as the 'big-five', combinations of which represented a source of grave health concern to Europeans both within and beyond their own borders.

7 ibid.

8 Compiled by T.D. Mayer. Reproduced from *Leprosy Review*, 3, 2 (1932), between pp. 68-69. The area of highest prevalence, at the seam of the page, centres on Ikom and Obubra.

9 Cochrane (1928), pp. 61-62. The terms 'prevalence' and 'incidence' are used in Cochrane's text to refer to what seems to be the same statistical measure, namely the number of people with leprosy in the population (i.e. the prevalence). I thank Lucy Carpenter for pointing out this inconsistency to me.

colony. 1921 census figures, applying solely to Northern Nigeria, put the number of those suffering from leprosy at 32,772 in a population of about 10 million, approximating to a prevalence of 3.2 per 1,000. He notes that a report made by a Mr. Oldrieve puts the number of leprosy sufferers at 4.7 per 1,000, and mentions what attempts were being made to treat the disease. In this regard, the CSM settlement at Itu, near Calabar, in the care of Dr. MacDonald is given specific mention,[10] though he comments that medical missionary work in Nigeria is not particularly advanced.[11] Cochrane tabulates treatment facilities throughout Africa, listing Nigeria as having 'three mission hospitals [giving] treatment, ten leper villages financed by emirates, [and] one government leper colony'.[12] It was at about this time that Dr. Harry Hastings, also CSM, began leprosy work in connection with his hospital at Uburu, in the Afikpo Division of Ogoja Province.[13]

In 1933, Hastings expanded the scope of his work, attending outpatient clinics at Osu Edda, where a number of clan-based leper villages had assembled, seemingly under the sponsorship of a local leader.[14] This development was favourably commented upon by Muir in his report on anti-leprosy work in Nigeria in 1936,[15] and seems to have provided the template for clan-based settlements later adopted at Oji River (Onitsha Province) and Uzuakoli (Owerri Province).[16] At the same time, the relatively small scale of Hastings' enterprise, its confinement to areas adjoining Uburu, and the fact that the leprosy control work ran as an adjunct to a general hospital made it an unlikely template or centre for province-wide work.

[10] ibid.

[11] Cochrane (1928), p. 62. He notes that of 525 missionaries in Nigeria, only 18 are doctors.

[12] Cochrane (1928), p. 73.

[13] NAE, OGPROF 2/1/1789, p. 341. Copy of letter dated 13th Dec., 1943 from Dr. Harry Hastings to unknown correspondent. Also p. 349. Letter dated 31st Jan., 1944 from the Resident, Ogoja Province to the Secretary, Eastern Provinces, Enugu. These letters date the beginning of leprosy work based at the already extant mission hospital at Uburu to 1927.

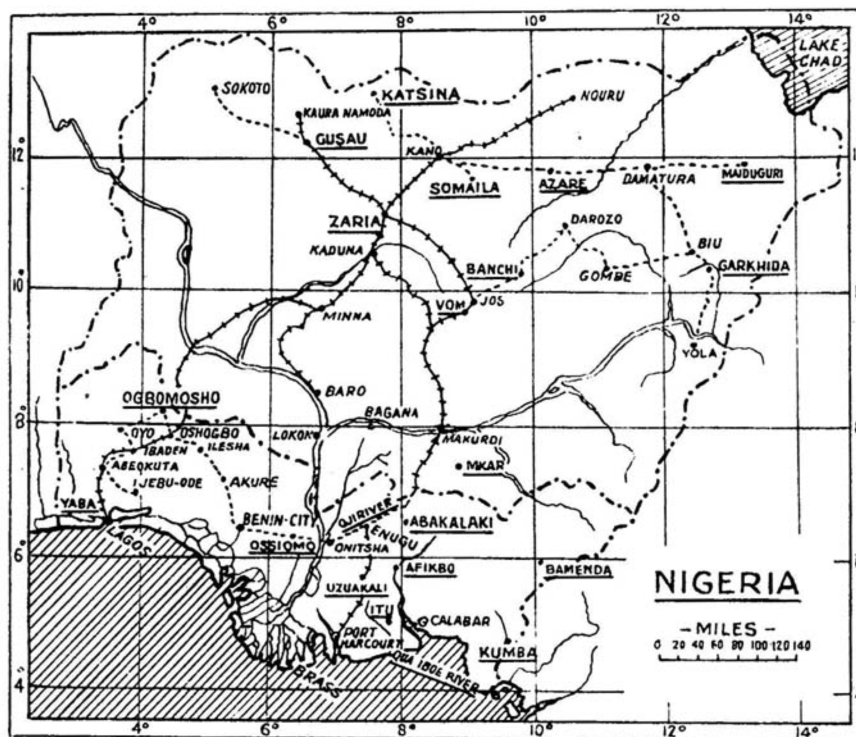
[14] NAE, OGPROF 2/1/1789, p. 341 – see above. Hastings notes that treatment at Osu Edda began 'within three months of our first obtaining a lorry'. Also see E. Muir, 'Leprosy in Nigeria: A Report on Anti-Leprosy Work in Nigeria with Suggestions for Its Development', in *Leprosy Review,* 7, no. 4 (1936), p. 163. Muir writes '[a] native land-owner of the Edda Clan, himself a leper, established a leper village to which other lepers of this clan were gathered. There are now five such villages within a radius of some 3 to 4 miles from a central treatment centre at Usu, which is on the main road some 10 miles west of Afikpo.' It is difficult to establish the relationship between the availability of treatment in the locality and indigenous efforts to band together in leprosy settlements in this area of Nigeria

[15] Muir (1936), p. 163.

[16] NAE, OGPROF 2/1/1789, pp. 338-40. Letter dated 17th Dec., 1943 from Mr. R.B. Cardale, District Officer, Afikpo Division, to the Resident, Ogoja Province. Cardale writes 'Dr. Hastings' Treatment Centre at Osu proved to be a prototype. Owerri and Onitsha followed his example'.

The most important means of treatment available to early workers concerned with leprosy control in Nigeria was a derivative of the oil of the hydnocarpus tree named Chaulmoogra oil. It seemed to contemporary leprosy workers to arrest tuberculoid leprosy, and the disadvantage of painful administration by injection had been partly solved in the early 1920s by Leonard Rogers in India.[17] Both MacDonald and Hastings used this remedy;[18] indeed it formed the centrepiece of what seemed to make their settlements attractive to leprosy sufferers far beyond their natural catchment area.

Colonial administration and leprosy in Ogoja – 1934



Map 6: Leprosy settlements in Nigeria, 1937[19]

The attractiveness of new treatment opportunities is demonstrated by an early account of the impact of leprosy control schemes and the scale of the local leprosy problem in Ogoja, given in a 1934 official letter discussing a leper camp at Abakaliki. It is stated that a count in Ogoja

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17 J. Iliffe, *The African Poor*, (Cambridge, 1987), p.219.

18 R. Schram, *Heroes of Health Care in Africa,* (Freshwater, Isle of Wight,1997), pp. 106, 107. Schram writes '[b]y 1932 [Hastings} opened a Leprosy Settlement Clinic. 20 miles away the police asked Dr. Hastings to do a post-mortem on a murderer's victim. He was discovered to have leprosy. This discovery led to finding many other leprosy patients in a refuge - all without treatment. In the end Hastings brought treatment to five such pathetic villages!'

19 British Empire Leprosy Relief Association. Annual Report. (1937), p. 4. Settlement locations are underlined.

and Ikom Divisions returned an incidence of leprosy of 7.4 per 1,000, which could be generalised as a 7 per 1,000 incidence province-wide, or upwards of 5,000 leprosy sufferers among a population of 725,000. Of this number, 529 are noted as having joined settlements, of which 66 were at Uburu (among a total population of 233), 46 at Abakaliki (among 62), 150 at the Dutch Reformed Church settlement at Mkar, Benue Province (where treatment was also available under the supervision of a medical doctor), and 267 at Itu.[20] The fact that patients from these divisions were seeking to address their problems in this way attests to a high degree of local recognition of the significance of leprosy, and a strong consciousness of what means were available for altering the condition of the leprosy sufferer.

It remains difficult to discern the motivations behind apparently spontaneous leprosy settlements, such as that at Abakaliki and those discovered by Hastings at Osu Edda, from official correspondence. The complexity of patterns of incidence of leprosy, degree of stigma suffered, and levels of access to local resources by groups of sufferers is readily acknowledged by Muir.[21] While it is clear that the existence of effective treatment motivated many sufferers to travel to newly-organised settlements under the care of European medical personnel, it is less clear whether locally organised leprosy settlements represented a response to expulsion of leprosy sufferers from their communities or an agreed procedure guaranteeing sufferers access to land and resources.

From the point of view of Native Administrations, and thus of official correspondence, the problematic issue regarding any gathering of leprosy sufferers was that of cost. The letter concerning the Abakaliki settlement discusses the costs involved in maintenance of Ogoja leprosy patients – the Abakaliki settlement is said to be 'self-supporting, apart from the cost of drugs and medical supervision', of which no details are given.[22] The Afikpo Native Administration (N.A.) provides paid employment to leprosy patients at Uburu for road

[20] NAE, OGPROF 2/1/1788, pp. 1-5, Letter dated 24th Apr, 1934 from the Resident, Ogoja to the Secretary, Southern Provinces, Enugu. On p. 1 the author reports that '1,008 lepers have been counted in a population of 135,930'.

[21] Muir (1936), p. 152. Muir writes 'there are economic, educational, sociological and other factors which have an important bearing on the leprosy problem. All of these have to be studied if this difficult disease is to be understood and in the end effectively controlled. And it is not sufficient to study them in one country or among one race alone, for they vary in every land and in every province, among every tribe and people'.

[22] NAE, OGPROF 2/1/1788, pp. 1-5. See page 2 for this reference.

maintenance. Obubra and Afikpo N.As. grant a total of £100 per annum to Itu, which does not cover the cost of supporting 267 patients there, while a grant of £50 per annum is promised to Mkar, where costs are substantially lower than at the by then highly developed settlement at Itu.[23]

A 1932 inspection of the camp at Abakaliki by the Senior Health Officer, Enugu, detailed the insanitary conditions and the shortage of land at the current location and proposed another site at Mile 55 on the Enugu-Bansara road. The provision of a small grant for the purposes of erecting a new camp at this site and of compensating the owners for loss of farming rights is seen as preferable to disbanding the residents to either Uburu or Mkar, while the 'prohibitive' cost of Itu precludes sending them there.[24] This concern with minimising the cost to Government, even to the extent of encouraging informal and often insanitary settlements, was to remain in tension with the desire to localise provision for treatment and control of leprosy throughout the next decade, and was at the heart of the failures and troubles besetting attempts to institute a Provincial Leprosy Control Scheme for Ogoja.

It is perhaps easier to see why this might be the case through analysis of the financial basis of Native Administration in Southern Nigeria at this time. Following the Women's Movement of the late 1920s across southern Igbo areas protesting against the legitimacy of new taxation, the reorganisation of the political basis of native administration in south-eastern Nigeria was seen as a necessity. The result was an atomisation of political and fiscal power which saw the unit of native administration related directly to local clan courts.[25] The proliferation of small administrative divisions meant that on the one hand strategic authority was often aggregated to the European Resident of a Province, and on the other hand the individual revenue generating capacities of Native Administrations was often very low.

This was even more the case in Ogoja Province, where communications difficulties and the lack of exportable commodities rendered the province's administrations among the least

[23] ibid., pp. 2-3.
[24] ibid.,pp. 3-5. The Senior Health Officer’s 1932 inspection report is quoted at length in this letter.
[25] Perham (1937), chs. XIV-XVI. Perham outlines the rationale behind the reorganisation, stressing the need to make local revenue collection seem relevant to local concerns.

productive in terms of revenue in all of Nigeria.[26] While central tax revenues were disbursed to Native Administrations, and formed a considerable portion of the monies available to eastern administrations, the principle of targeting administrations according to their development needs had not been universally acknowledged in the period under discussion; thus poorer Native Administrations had very little leeway when it came to providing novel services in their own area.[27] The evolution of a broader capital fund for the seeding of such services had to await the later years of World War Two.

26 This was still the case in the mid-1950s; see Buchanan & Pugh (1955), pp. 88-93.

27 B.H. Bourdillon, in A.H.M. Kirk-Greene, ed., *The Principles of Native Administration in Nigeria: Selected Documents 1900-1947*, (London, 1965), pp. 226-37. The 1939 Bourdillon Minute, reproduced here, deals with this debate in some detail, prompting a concerted effort to rebalance regional disparities in income and provision in subsequent years.

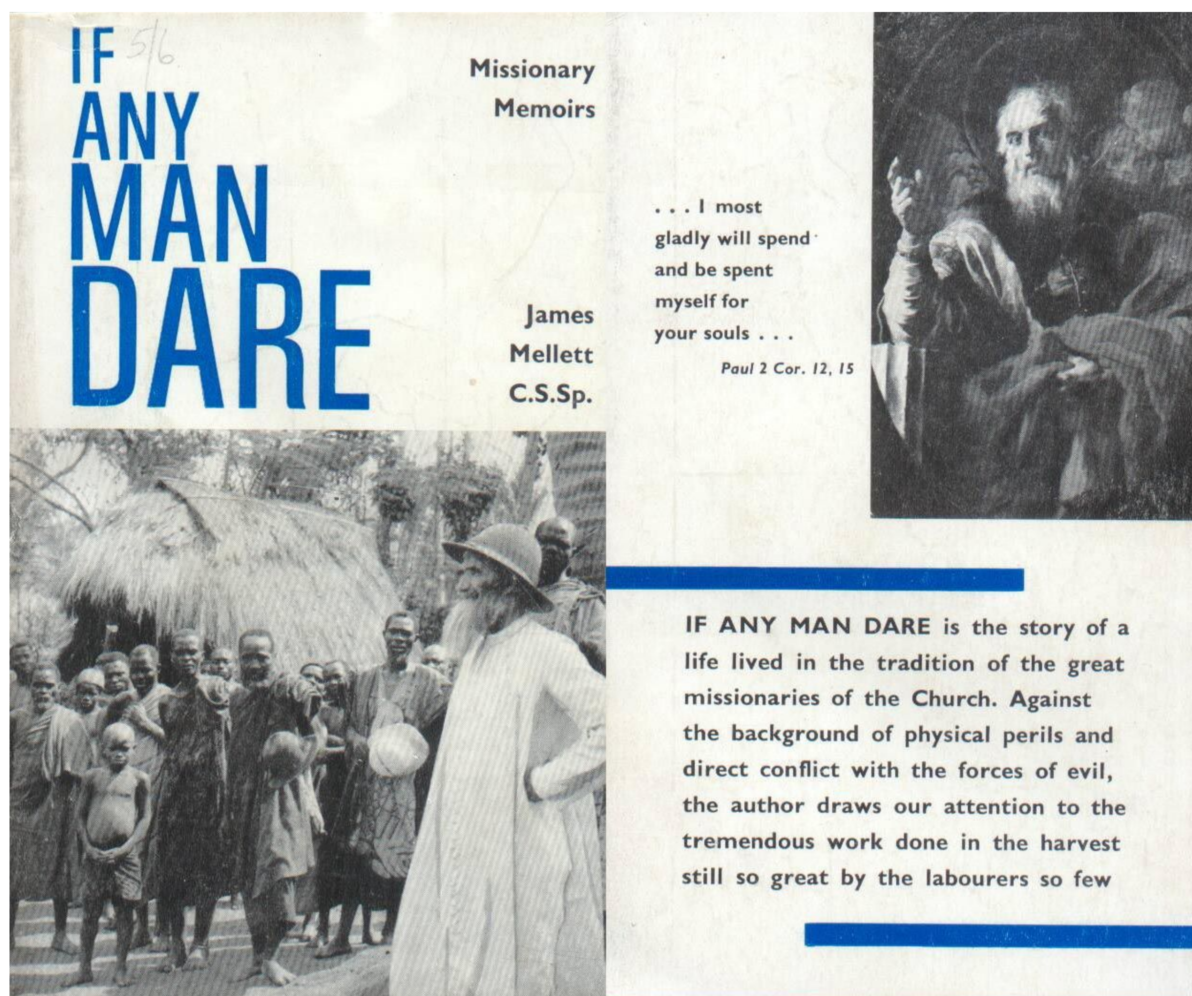

Figure 1: Cover from memoirs of a founder of the RCM in Ogoja, 1921[28]

For leprosy control, as for the fields of rural health and education, the government relied on missionary bodies to carry out essential work.[29] In Ogoja the presence of the Roman Catholic Mission (RCM) dated from 1921. In the eyes of its original Catholic evangelist, Fr. James Mellett, C.S.Sp., it encapsulated 'the challenge of the bush', beset by fear of witchcraft and the scourge of ritual title-taking societies,[30] a place where guests were housed in the beds of

[28] J. Mellett, *If Any Man Dare*, (Dublin, 1963), front and back covers.

[29] R. Schram, *A History of the Nigerian Health Services,* (Ibadan, 1971), ch. 16, S. Phillipson 'Grants in Aid of the Medical and Health Services Provided by Voluntary Agencies in Nigeria', (Lagos, 1949), para. 24. Both texts stress an element of partnership between government, native administrations and missions in the evolution of leprosy services, while stressing that leprosy work is 'a field that [the missions] have made peculiarly their own' (Phillipson, p. 34).

[30] Mellett, (1963), ch. 3.

lepers, and heads were taken in internecine retribution,[31] and where only the Church could bring consolation where the colonial state brought misery and chaos, even to its own servants.[32]

When the Province became the mission field of St. Patrick’s Society (Kiltegan) in 1930, a more permanent presence became possible. The earliest record of an expressed interest on behalf of the RCM in leprosy control in Ogoja Province dates from February 1936. Mention was made in official correspondence of a meeting between the Senior Health Officer of what were then known as the Southern Provinces, Nigeria, based in Enugu, and Monsignor Joseph Moynagh, then in charge of RCM activities in Calabar and Ogoja Provinces. It was noted that Moynagh was 'particularly anxious to undertake leprosy work in the Ogoja Province' and that he had been advised to 'formulate concrete proposals',[33] there being an acknowledged need for a Provincial Colony in Ogoja to supplement 'the unsuitable settlement in Abakaliki, and the small settlement in the Afikpo area'.[34]

In the course of the subsequent eighteen months, a number of sites were assessed and proposals costed by the acting Resident at Ogoja and the Father-in-charge at the RCM.[35] These proposals were discussed with Moynagh in Calabar, and with the Senior Health Officer in Enugu and the Director of Medical Services in Lagos. In examining the course of what ultimately was a failed proposal, it is possible to tease out a bit more clearly the constraints imposed by the largely implicit political, religious and medical agendas brought on board. From this can arise an understanding of how the emerging discourse on leprosy control in Nigeria was taking shape, and in turn shaping leprosy control efforts at local level.

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31 Mellett (1963), chs. 4, 8.

32 Mellett (1963), ch. 8 describes a multiple hanging at Bensan, near Ikom, at which Mellett officiated for the purposes of Baptism. He writes 'the officials had simply to give a directive hand in what was... a mere mechanical routine... the priest's is the hardest work at an execution... I was physically and emotionally exhausted. But I had done a priest's work. The Police Inspector, an Englishman, who had supervised the executions committed suicide three weeks later.'

33 National Archives, Enugu (NAE), OGPROF 2/1/1788, p.6, Letter dated 4th Feb., 1936 from the Senior Health Officer, Southern Provinces, Enugu to the Director of Medical and Sanitary Services, Lagos, endorsed to the Resident, Ogoja Province.

34 ibid.

35 According to Kiggins (1991), this was originally Fr. Manus McLafferty, and subsequently, by Jan 1937 at the latest, Fr. Paddy Costelloe.

At an early stage in the negotiations, Moynagh's ideas on what might represent worthwhile 'leper work' are spoken of as 'rather vague'.[36] At the same time, there existed no formal template for what a 'provincial leper colony' might look like or what strategic function it might perform within the larger agenda of leprosy control. Despite the acknowledged need for something along the lines of a provincial colony to serve a population of patients which was suspected to be quite high, there was as yet no notion as to whether any colony created would be expected to serve the entire area or to work as a centre with satellites. This would become very clear in the subsequent negotiations on the mission proposals.

The RCM acceded to the principles stated by the acting Resident in Ogoja, Mr. G. B. Williams, that the settlement should serve the worst area for leprosy and be well sited for either road or river transport. Moynagh nonetheless objected to the proposal that it be sited at Bansara, where he felt that the health of both the doctor and the patients might suffer.[37] It seems that Moynagh and the priest in charge of the RCM in Ogoja, Fr. Manus McLafferty, had a site at Okpoma off the Yahe-Ogoja road in mind,[38] but Williams prevailed upon the RCM to seek a site near Bansara. A site was chosen, and in a meeting between Williams, McClafferty and a Mr. Naish the advantages and disadvantages of the chosen area were discussed. Naish suggested that the site was too near the village of Bansara Abakpa and that a similarly well watered site, with equally good farming land for the purposes of self-sufficiency could be found near the Bansara-Ikom road. Williams imagined that 1,000 acres should be sufficient if McClafferty could negotiate this.[39]

The next recorded discussion regarding the proposed leprosy settlement was between Williams and Moynagh in early September 1936. By this stage the RCM had decided on a new site, nearer to Yahe, and was in a position to guarantee a doctor for leprosy work within

[36] NAE, OGPROF 2/1/1788, pp. 9-10. Notes of a meeting between Moynagh and Acting Resident in Ogoja Province, Mr. G.B. Williams, dated 8th April 1936. While McGettrick, Prefect Apostolic of Ogoja from 1940, wrote much on the subject of leprosy, it is difficult to gauge RCM attitudes to leprosy at this time in any specific fashion.

[37] ibid.

[38] NAE, OGPROF 2/1/1788, p. 11. Letter from Fr. Manus McLafferty to the acting Resident, Ogoja Province, dated 28th April 1936. It is unclear from this letter whether the site at Okpoma had already been made available to the mission in principle.

[39] NAE, OGPROF 2/1/1788, pp. 13-14. Notes of a meeting between G.B. Williams, Fr. Manus McClafferty and Mr. Naish dated 29th April 1936.

six months if needed. The Resident underlined the need to see some estimates as to the cost of the scheme so that the financing could be worked out. Moynagh put the initial cost of the scheme at £1,815, including a doctor's house and salary, dispensary, office, store, patients' housing, equipment, and maintenance for patients. This was beyond the capability of the mission to fund alone, and Moynagh asked what grant the work could expect from Government and from Native Administrations. Moynagh also pointed out that the mission might be in a position to see what could be done for cases isolated in surrounding villages once the settlement had been started.[40]

Williams summarised the position in a letter to the Secretary for the Southern Provinces in Enugu. He added his own set of estimates based on the Ossiomo Settlement in Benin Province, giving figures of £1,000 capital costs and £867 per annum recurrent costs. Two points in particular stand out from his presentation – that Native Administrations in the area could only be expected to provide in total about £300 per annum, and the scheme seemed dependent on a Government grant, and was thus too nebulous for him to be able to present to the Native Administrations as a *fait accompli*.

In a remarkable passage, quoted below, he confesses his inability to judge the value of the scheme from a medical point of view, while presenting an argument that essentially destroys the case for Native Administration subvention. Using the indisputable fact that the proposed settlement would only represent a beginning of a provincial leprosy control scheme, he claims that such settlements

> must I think be regarded either as valuable medical research centres or as charitable institutions for the benefit of a few individuals… If they are to be regarded as research centres it is… unfair to ask a few Native Administrations to support them and they should be maintained by the country as a whole. If they are charitable institutions for the benefit of the few they should be supported by charity.[41]

The following month, in receipt of Dr. Muir's interim report on anti-leprosy work in Nigeria,[42] Williams rephrased his concerns in terms borrowed from Muir's template for successful leprosy control in Nigerian circumstances. Armed with arguments from a public

[40] NAE, OGPROF 2/1/1788, p. 17. Letter dated 9th Sept 1936 from Rev. J. Moynagh to the Resident, Ogoja.
[41] ibid., p. 21.
[42] This report formed the bulk of the Oct 1936 edition of *Leprosy Review* (Vol. 7, No. 4), together with material on the Gold Coast and Sierra Leone.

health perspective, he goes on to demonstrate that any scheme along the lines proposed by Muir was over-ambitious for the state of development reached in Ogoja Province at that time. Drugs, dressings, the training of sanitary inspectors, the hiring of sufficient European staff were all seen as beyond available resources, requiring an investment of 'at least £5,000 a year', of which only the £800 currently given to Mkar and Itu by Ogoja Native Administrations could be raised locally.[43]

[43] NAE, OGPROF 2/1/1788, pp. 27-29. Letter dated 27th Oct 1936 from G.B. Williams, acting Resident, Ogoja, to the Senior Health Officer, Southern Provinces, Enugu.

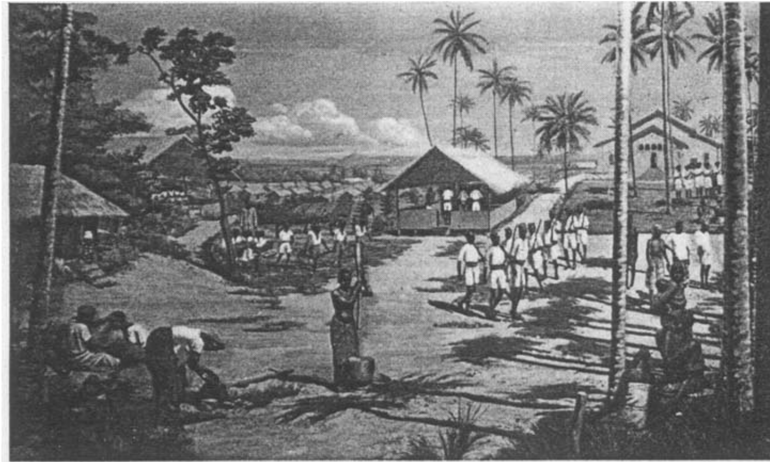

Fig. 1.

This picture depicts a leper colony in Nigeria. From the Left notice :—

a. Women pounding their meal and cooking.
b. Beyond them a cottage with a mother and her children.
c. Boy Scouts playing a game.
d. Beyond them cultivating fields, orange groves and neat rows of thatched cottages.
e. To the right of the scouts, notice the leper police drilling, and behind them the court of justice, where a leper chief tries delinquents.
f. See the tall palm trees from which the lepers gather the fruit and make palm oil, so useful for food, soap-making, etc.
g. In the background is the church, which holds 1,200 people—built at an expenditure of £120. In front of it is an excellent brass band playing. All is the work of the lepers.

Fig. 2.

This picture is continuous with the last. Beginning from the left :—

a. Notice the leper in the foreground.
b. Behind him is a dispenser making medicines for injection from chaulmoogra oil. The oil is mixed with chemicals and put in the sun for a fortnight to mature.
c. Behind him is an inunction parade. Each child is rubbing chaulmoogra oil into the child in front of him.
d. Behind these children is the treatment room. The doctor is seeing patients in the veranda. An assistant is seen through the window examining slides under a microscope, and another giving injections to the patients.
e. To the right of the treatment room lepers are repairing the road, while still further to the right they are busy with palm-oil manufacture.
f. In the right front corner is the children's creche, where new-born children are isolated and looked after by trained native nurses, so that they may not come in contact with their infectious parents. Two of the mothers are watching their children from the distance.
g. In the centre is a native orchestra made up of instruments prepared by the patients themselves. Beyond, the patients are seen dancing to the music.

Figure 2: The ideal leprosy settlement[44]

[44] *British Empire Leprosy Relief Association. Annual Report.* (1937), p. 2.

While both the RCM and the colonial administrative and medical authorities seemed to agree on the outlines of the ideal leprosy service, a major difficulty in Ogoja, at this point in time, lay with the means of linking the administrative responsibility to provide province-wide care with the mission's desire to work from a specific centre. Before the publication of Muir's report, the connection seemed nebulous despite the existence of certain small-scale exemplars such as Uzuakoli and Ossiomo. This accounts for Williams' stark positing of the research-charity dichotomy as shown above. The difficulties raised by the financing of local government, which were exercising Bernard Bourdillon, the Governor of Nigeria, at this point in time, made it almost impossible to frame and co-ordinate policy on any large-scale project in an isolated area such as Ogoja Province.

In December 1936, Williams informed the RCM in Ogoja that leprosy control policy was currently being reconsidered by Government and that further expenditure was unlikely to be committed at that time. He restated his estimate that £5,000 per annum would be needed from a combination of Government and mission sources in order to give leprosy control along the lines proposed by Muir any chance of success in the province, and asked what proportion of this the mission might be able to contribute.[45] The Director of Medical Services in Lagos, while accepting in principle the desirability of aiding approved leprosy colonies, wished the RCM to provide more detailed particulars comprising not only financial estimates, but also planning and functions of the settlement in its day-to-day operation.

This request was communicated to Fr. Costelloe, who for his part wanted to make clear that the financial policy of the RCM was to 'meet expenses as they came' rather than promise a specific amount in advance. In his communication to Costelloe, Williams suggested how the mission's proposal should be phrased and how the estimates should be reformulated in the light of Muir's recommendations for leprosy control. Costelloe, in consultation with Moynagh, eventually promised to provide £1,000 per annum, which amounted to one quarter of the revised estimated cost.[46]

[45] NAE, OGPROF 2/1/1788, pp. 34-35. Letter dated 21st Dec 1936 from G.B. Williams, acting Resident, Ogoja, to the Father-in-charge, RCM, Ogoja.

[46] NAE, OGPROF 2/1/1788, pp. 36-43, 52-53. Memorandum dated 24th Dec 1936 from Director of Medical

In response to this, Williams proposed to the Secretary, Southern Provinces, that the Government assist the mission to pay a doctor and that the work proceed from the ground up rather than from a central settlement. It seemed that the original proposals put forth by the mission and formulated in co-operation with local and regional administration proved too ambitious at this point in time. Government was only willing to consider a grant of £500 per annum and wondered whether the Native Administrations could provide a further £2,500, even while they conceded that 'a good case for a leper settlement in Ogoja Province would appear to have been made out'.[47]

As the plans to build a leper settlement for Ogoja Province began to be developed and take shape through 1936, it became clear that the relatively unprogrammatic and chaotic nature of its development into something like a leprosy control scheme was creating difficulties for all parties involved. Williams later wrote that Costelloe seemed satisfied to proceed with a system whereby a doctor stationed at Ogoja would visit clans and villages attempting to set up village leper settlements.[48] This ran into problems with the Director of Medical Services' insistence that such work be co-ordinated by an experienced leprosy expert,[49] and though this position was later modified, it seemed that the momentum behind the project had dissipated amid the problems posed by the complexities of co-ordinating the variety of bodies involved. The introduction of Muir's ideas at this point in what had been an *ad hoc* and largely unprecedented process in mission-government co-operation[50] did nothing to clarify the issue.

The lack of co-ordination, coupled with the highly ambitious nature of the scheme in an area which still lagged far behind most of Southern Nigeria in terms of infrastructural

Services, Lagos to Senior Health Officer, Enugu, endorsed to Resident, Ogoja Province. Letter dated 8th Jan 1937 from Fr. Costelloe, RCM Ogoja to the Resident, Ogoja. Letter dated 20th Jan 1937 from the Resident, Ogoja to the Father-in-charge, RCM Ogoja. Letter dated 8th May 1937 from Fr. Costelloe, RCM Ogoja to the Resident, Ogoja.

47 NAE, OGPROF 2/1/1788, pp. 61-62. Memorandum from Director of Medical Services, Lagos to Senior Health Officer, Enugu, endorsed to the Resident, Enugu.

48 NAE, OGPROF 2/1/1788, pp. 114-17. Letter dated 30th Nov 1939 from Resident, Ogoja Province to Secretary, Eastern Provinces, Enugu.

49 NAE, OGPROF 2/1/1788, p. 73. Memorandum dated 17th Sept 1937 from Director of Medical Services, Lagos to the Senior Health Officer, Enugu.

50 While the leprosy settlement at Ossiomo had been set up in 1935 by Government and transferred to RCM medical staff, settlements such as those at Itu and Uzuakoli had already been in existence when government began to aid them. The sort of co-operation envisaged in Ogoja seems to have been unique.

commitment on the part of the colonial government, made success at this point in time unlikely. Framed at a time when new methods of dealing with leprosy in Nigeria, with a solid grounding in public health methodology,[51] were being elaborated and disseminated, and while the RCM were still only establishing their presence in Ogoja,[52] it is perhaps no surprise that plans for RCM leprosy work in the province were abandoned at this juncture. As Williams put it in 1939, the constant debate over the qualifications necessary of the medical officer, the sources of the funding, and about accountability and authority had meant that '[by October 1937] the Mission had, I think, become convinced that no progress was likely and the matter dropped'.[53]

Leprosy and local politics - 1938-1939

That the perceived public health problems posed by leprosy in the Province persisted and continued to impinge on local politics and administration is attested to by a number of sets of leprosy-related correspondence in files relating to the administration of Ogoja Province. Events at Abba Omege, and at Amaseri in Afikpo Division, and at Ugep in Obubra Division demonstrate that concerns with the use of common agricultural and medical resources by leprosy sufferers led to complaints by local councils and to petitions for more secure conditions from among groups of leprosy sufferers themselves. These sets of correspondence are also significant in that they provide evidence, for the first time, of groups of leprosy sufferers responding to opportunities provided by existing government health interventions such as dispensaries, as well as using their condition as leverage in disputes about access to

[51] This grounding is made explicit in the section of Muir's report dealing with the concept of leprosy as a key disease in spreading notions of proper diet and sanitation among the rural population, as well as in providing a location in which treatment for a wide range of ancillary conditions could be administered – see Muir (1936), pp. 155, 166.

[52] Kiggins (1991), pp. 131, 137, 145-61. At this time, St. Patrick's Society, Kiltegan was undergoing something of an upheaval which made their position in Ogoja very tenuous, since mission work was seen as progressing very slowly. Costelloe was called back to Ireland in 1938 to take over as Superior General of the society, and was replaced first by Mgr. Patrick Whitney, one of the society's founders, and then by Thomas McGettrick. Through this, they managed to retain hold of Ogoja as a mission field, which may have been on the basis of a promise by Whitney of more priests for the area in the near future.

[53] NAE, OGPROF 2/1/1788, pp. 114-17. Letter dated 30th Nov 1939 from Resident, Ogoja Province to Secretary, Eastern Provinces, Enugu.

land.

At Abba Omege, an 'unofficial'[54] leprosy settlement with 110 inhabitants had formed next to the dispensary and rest house, leading to charges that inhabitants were involved in livestock theft and pilfering, that they used the local water supply and occupied land which belonged to a local whose 'period of crop rotation [had] come round for him to farm there'.[55] The Resident advised against dispersing the settlement, though he agreed that it should be reduced tactfully, and that inhabitants from outside the division should be rehoused in their own division, and that those from outside the clan be housed with their own clan if possible. He based this course of action on the assertion that such small settlements were a good way of dealing with the leprosy problem, though the permission of the landowners should ideally be sought in advance.[56]

At Ugep, the village council moved to ask the Native Authority to compel labour for the construction of a leprosy camp to stop the mingling of 'lepers' with 'healthy people'.[57] The District Officer for Obubra Division commented in a letter to the Resident that the nature of the problem was not such that labour could be compelled, but that leprosy sufferers choosing segregation were entitled to the sympathy and support of the council and could reasonably expect assistance in housing and farming.[58] He concluded with the remark that

> [t]his is a preliminary minute indicating my thoughts on a problem of which the Native Authorities are increasingly aware; and for which adequate funds are not likely to exist for many years to come.[59]

At Amaseri, a leprosy camp was constructed on the Amaseri-Okposi road, on Okposi land. It is unclear whether assent was eventually received from Okposi for this, and to whom the

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54 NAE, OGPROF 2/1/1788, p. 95. Copy of telegram dated 16th Sept 1938 from O'Neil Hospital, Obubra to Resident, Ogoja and endorsement dated 21st or 22nd Sept 1938 from Resident, Ogoja Province to District Officer, Afikpo. This page forms part of a correspondence stemming from a letter, dated 14th Sept 1938 from the District Officer, Afikpo to the Resident, Ogoja [NAE, OGPROF 2/1/1788, pp. 92-93] which links the genesis of the Abba Omege settlement to dispensary work conducted from Obubra, a charge denied in the telegram mentioned above, which states '[p]ersonally consider specific treatment at such intervals contradicted as useless and possibilities medical supervision inadequate for establishment of settlement'.

55 NAE, OGPROF 2/1/1788, pp. 92-93 – see above for details.

56 NAE, OGPROF 2/1/1788, p. 94. Copy of telegram dated 16th Sept 1938 from Resident, Ogoja to Hospital, Obubra with endorsement of the same date from Resident to District Officer, Afikpo.

57 NAE, OGPROF 2/1/1788, p. 102. Copy of minutes of Ugep Village Council meeting on 22nd Mar 1939.

58 NAE, OGPROF 2/1/1788, pp. 100-01. Letter dated 1st May 1939 from District Officer, Obubra to Resident, Ogoja.

59 ibid., p. 101.

assent may have been given.[60] The lepers at Amaseri petitioned the Resident, on tour in Afikpo, to let them remain in the area they had been sent to and to arrange for them to receive medical treatment at that location. Specifically, they pointed out that the land dispute surrounding the location of their camp had been solved between themselves and the landholders, and that the issue of their location was separate from problems between Amaseri and Okposi. The Resident and the District Officer attempted to arrange for them to be treated by Hastings from Uburu, while insisting that, properly speaking, Amaseri lepers should be housed on Amaseri land. They suggested sites near the border with Osu Edda, where a clinic already existed. Hastings proved unable to take on the workload however, and the correspondence ends with a plaintive note from the Resident: 'Once a site has been agreed upon it may be possible to do something to help these unfortunate people'.[61]

In all three cases, as with the earlier settlement at Abakaliki, clear evidence of local concern with leprosy is demonstrated by the events outlined. Local concerns were articulated as requests for some form of policing, either by means of funding segregation, protecting markets and local resources from contamination, or providing medical aid to those who had segregated themselves either in a deliberate quest for therapy (as evidenced by the gathering around the dispensary at Abba Omege) or a request for treatment from an already existing leprosy centre (as at Amaseri).

Seeds of change at the RCM in Ogoja, and in Nigerian policy on leprosy control, 1939-1945

From the perspective of a missionary-centred history of Ogoja Province, the most striking

[60] NAE, OGPROF 2/1/1788, pp. 105, 107, 109, 110. Letter, petition, dated 6th July 1939 from 'Lepers at Amaseri' to the Resident, Ogoja. Letters dated 5th Aug and 20th Oct 1939 from District Officer, Afikpo to the Resident, Ogoja. Letter dated 9th Nov 1939 from the Resident, Ogoja to District Officer, Afikpo. The District Officer writes [5th Aug 1939] 'Now they allege that they have obtained permission from Okposi to build'. It is not clear whether the 'they' here refers to Amaseri as a whole or the subset suffering from leprosy. The petitioners felt themselves to be unconnected with Amaseri, seemingly on account of their health status, but felt that agreement had been more or less secured for them to go on living at 'the place we are pointed'.

[61] NAE, OGPROF 2/1/1788, p. 110 – see above for details.

and influential personage to preside over the recent history of the province has been Thomas McGettrick, appointed Vicar Apostolic of Ogoja in 1940. McGettrick's previous missionary experience had been between 1934 and 1940 at Anua, one of the earliest, most extensive and more institutionally developed Kiltegan missions,[62] in an area with a long history of Protestant missionary work.[63] It was in this context that he developed the outlines of his missionary theory, practice and concerns, which were to be so influential in the context of welfare politics in Ogoja. In order to ground a narrative of nascent leprosy control in Ogoja, it is therefore necessary to outline both McGettrick's approach to mission, and his early encounter with leprosy sufferers among the Nigerian Catholic population.

Thomas Kiggins noted that McGettrick had a reputation for harshness while at Anua, particularly in the context of Christian marriage, a harshness he later regretted.[64] At the same time, the innovation of Marriage Training Centres, introduced in Anua by McGettrick,[65] and retained as a cornerstone of his missionary practice in Ogoja, seemed to contribute greatly to the statistical and spiritual success of Anua mission. These centres blended an emphasis on householding and childcare with preparation for the receipt of Catholic sacraments. An increase in the number of Catholics from 10,000 in 1936, to 20,000 three years later was taken as a measure of a prospering mission, one which seemed to fulfil the wishes of the Superior of the Kiltegans, Paddy Costelloe

> that our missionaries will continue to go forth, year after year, to labour in pagan lands for the formation and preservation of happy Catholic homes like those we have in our own little island.[66]

The harshness exhibited in the routine of 'dragooning' women as participants into Marriage Training Centres, against the objections not only of their own families but often also of the families into which they had married according to local practice, and in the policy of public

62 Kiggins, (1991), p. 63, details the 1930 negotiations resulting in the granting of the Calabar, Uyo and Ogoja mission territories to the new St. Patrick's Society. The former pair had been developed by the Holy Ghost Fathers under Bishop Joseph Shanahan over the previous quarter century, while Ogoja did not yet have a permanent Catholic clergy. Anua mission is a short distance from Uyo town, and from Itu. The Uyo area had a longstanding Church of Scotland missionary presence, and the population is mainly of Ibibio ethnicity.

63 R.I.J. Hackett, *Religion in Calabar: the Religious Life and History of a Nigerian Town*, (Berlin, 1989).

64 Kiggins (1991), pp. 153-54, 158-59. McGettrick's regret is noted from an interview he gave in 1988.

65 McGettrick (1988), p. 105 notes these Marriage Training Centres as the first of their type in the Eastern Region of Nigeria.

66 Kiggins (1991), p. 145.

penance which took the form of compulsory attendance at Mass and prayers and manual work on the mission compound (seen as tantamount to imprisonment)[67] did not carry over into McGettrick's regime in Ogoja, as much due to practical administrative difficulties posed by the new Prefecture's geographical and linguistic terrain as to refinements in McGettrick's approach to African Christians. The gendering mechanics implied by the separate institutional focus on male and female educational, household and doctrinal practice provided a template for the range of services developed under the auspices of the RCM Ogoja Prefecture and Diocese. While the availability of suitable staff, whether male or female, did much to determine the profile of activities undertaken by the diocese, the internal RCM debate on recruitment, suitability, and the division of medical, administrative, education and catechetical labour was strongly influenced by a gender politics implicit in McGettrick's evolving missionary theory and vision.

While at Anua, McGettrick encountered Dr. Louba Lengauer, a Belgian-educated Russian Catholic, who had been employed to open the St. Luke's RCM Mission Hospital, founded at Anua in 1933. This hospital was one of the Anua mission's most troubled enterprises in the period before World War Two, left without a doctor in charge for four separate spells between 1934 and 1942. Lengauer's team was removed in 1935 following a protest lodged against a religious Sister on the staff, while her eventual replacement died shortly after his arrival. A German doctor employed in 1937 was interned at the outbreak of war in Europe, and it was only in 1942 that the MMMs were in a position to ensure a continued medical presence at the hospital.

Both Lengauer and the MMMs were to remain central to McGettrick's conception of what services a mission should provide. Lengauer's interest in leprosy encouraged her to take her medical team with her to Ossiomo, near Benin City, in 1935 to found a settlement which

[67] Kiggins (1991), pp. 153-54 details the controversy surrounding Christian marriage in Calabar and Uyo, noting that 'it was very important for the early missionaries to stress the full demands of the Church, in order to establish Christian marriage as something more than a theoretical ideal'. The Ibibio Union made explicit complaints to the District Officer at Uyo in 1939 about McGettrick's practice of 'arresting women and holding them against their will' in Anua. As a result of a Government investigation, which vindicated an unrepentant McGettrick, the severity of the penances was reduced, the Training Centres remaining more a feature of McGettrick's practice than a general Catholic missionary, or even Kiltegan, technique.

would later become one of the Nigeria Leprosy Service's inaugural institutions. This event is signalled in McGettrick's memoirs, echoing his reminiscences of difficult encounters with the nearby Church of Scotland Mission (CSM) Leprosy Settlement at Itu, where McGettrick notes being denied access to the approximately one-third of Itu's residents who were Catholic. The disillusion experienced by McGettrick regarding the spiritual isolation of Itu's Catholics resolved itself into a determination to found a leprosy settlement under Catholic auspices.[68]

Arriving in Ogoja in late 1939, McGettrick was under few illusions as to the difficulty of the missionary labours ahead of him. As he writes:

> In the old days Ogoja was called 'The Lost Province'. It was really a traceless praierie [sic]…. There were cycle tracks to Obudu and Ikom… Your best friend was a good walking stick; even a push cycle was not much use as the paths to the towns were worn deep by the feet of the thousands that tramped them.[69]

Almost immediately, however, his determination to found a Catholic leprosy settlement was strengthened by his encounter with *ad hoc* leprosy villages, and with mendicant leprosy sufferers outside churches and by roadsides. This encounter is dramatised in a variety of Catholic missionary narratives and hagiographies, including McGettrick's own memoirs, focusing expressly on the pitiful abandonment and disfigured misery of the leprosy sufferers. It is difficult to discern from the different versions of the story whether the village reputedly visited by McGettrick was that described by previous European observers at Abakaliki, but the experience of the colonial administration with the Abakaliki leprosy village had underlined the necessity of streamlining the administration of leprosy control.

From the perspective of the colonial administration, the first hint that any more than piecemeal help might be at hand was offered by the Leprosy Conference at Enugu on the 28th-30th August 1939, convened to benefit from the annual tour of the Medical Secretary of BELRA, Ernest Muir,[70] and leaving no doubt as to the emerging strategic significance of

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[68] McGettrick (1988), pp. 192-96. According to this account, Itu drew patients from as far afield as Onitsha, to where a regular motor service operated from the Settlement. The strong Igbo presence this catchment area would imply may account for the large number of Catholics at the Settlement.

[69] McGettrick (1988), p. 126.

[70] BELRA, *Annual Report*, (1939), pp. 5-6.

BELRA[71] in the Nigerian context, as it faded in importance in India. The resolutions passed at this conference constitute the first steps toward evolving a colony-wide policy on leprosy control. They call for the standardisation of statistics gathering, the evolution of a research focus, the linking of surveys to treatment along the lines drawn up by Muir, and the establishment of representative Provincial Leprosy Boards to co-ordinate leprosy control and relief, also following Muir’s suggestion that some means of co-ordinating the respective efforts of Government, Native Administrations and the Missions should be found.[72]

Muir's 1936 report on leprosy in Nigeria had set out a template for leprosy control: this was adopted as the 'Propaganda-Treatment-Survey' system at the Leprosy Conference.[73] Muir recommended that, further to the provincial leprosy boards, formed to co-ordinate local control efforts as exhaustively as possible, leprosy would be combated through a combination of provincial settlements with treatment, examination and training responsibilities, and clan-based settlements aiming at isolating all infectious cases in a cost-effective manner. The success of clan-based settlements would depend on a combination of propaganda and effective survey under the supervision of the Medical Officer of Health for the province and the medical officer of the provincial leprosy settlement.[74]

Consciousness of the necessity of acting on these resolutions in Ogoja was strengthened by the increasing unwillingness of the Settlement at Mkar to accept patients from Ogoja Province with the exception of those from around Obudu, many of whom shared the same

[71] In the British colonial context, one of the most important organisations for the co-ordination and pursuit of effective leprosy control was the British Empire Leprosy Relief Association (BELRA). In existence since 1924, it combined the research experience of notables such as Leonard Rogers, R.G. Cochrane and Ernest Muir and the propaganda appeal of a missionary organisation, so that 'the Empire was brought into the forefront in the battle for the control of leprosy'. Building on the belief that leprosy was curable, a belief predicated on the success of treatment with Chaulmoogra Oil in the Philippines and Calcutta, BELRA’s role as a spearhead of leprosy research was confirmed when the organisation’s medical secretary was chosen as the first Hon. Secretary of the International Leprosy Association in 1931. The refinement of leprosy survey techniques in India, and the collaboration with the volunteering group Toc H from 1934 helped bring about a climate in which co-ordinated leprosy control came to be seen as a viable form of social assistance, while BELRA had much success in canvassing colonial governments to adopt concerted leprosy control policies from the late 1930s onward.

[72] NAE, OGPROF 2/1/1788, pp. 112-13. Resolutions of the Leprosy Conference, Enugu 28-30 Aug, 1939. Muir (1936), p. 158 comments on the importance of the three bodies mentioned in the provision of care in leprosy.

[73] National Archives, Enugu (NAE), OGPROF 2/1/1788, pp. 112-13. Resolutions of the Leprosy Conference, Enugu 28-30 Aug, 1939.

[74] Muir (1936), pp. 158-59, 163-65.

ethnic origin and language group as the Tivi of Benue Province. This unwillingness was put down to complaints of 'financial stringency and… lack of sufficient staff', but also to the problems that patients from Ogoja Province were said to cause, as 'firewood wolves' denuding the countryside, and as traders in local markets, in spite of their condition.[75] McGettrick's arrival gave new impetus to the RCM leprosy control agenda, which together with the urgency gathering in the wake of the Enugu conference helped fashion a new consensus on leprosy control in Ogoja which would result in the founding of a fully-fledged RCM Leprosy Control Scheme in the northern half of the Province by the end of World War Two.

Muir's scheme was discussed at a meeting in the Resident's office, Ogoja, on the 28th Feb 1940, attended by the Resident, the Senior Health Officer, the Medical Officer, Ogoja, the District Officer, Ogoja and, as the new head of the RCM in Ogoja, Mgr. McGettrick. The difficulty of ascertaining either the suitability or the cost of the scheme was clear from the outset - the only working estimate regarding the prevalence of leprosy in the Province was given by the District Officer, who stated that 5% of total taxable males claimed exemption from paying on the grounds of leprosy.[76] The meeting agreed that a general survey of the province, carried out by a leprologist, would be necessary if a scheme appropriate to local conditions was to be drawn up.

Dr. Hastings' work with leprosy patients at the Church of Scotland Mission (CSM) at Uburu, in the Afikpo Division in the southwest of the Province - which was cited in Muir's report as innovative with regard to the development of clan settlements[77] - was mentioned at the meeting: the Senior Health Officer was asked to ascertain whether Hastings would carry out the survey for the Division. McGettrick commented that with 7,000 Catholics in the Province, the RCM could not afford the salary of a leprologist. The Resident pointed to

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[75] NAE, OGPROF 2/1/1788, pp. 114-17. Letter dated 30th Nov 1939 from Resident, Ogoja Province to Secretary, Eastern Provinces, Enugu. Letter from Chairman of the Dutch Reformed Mission, Mkar, from which these remarks are taken, quoted on page 116.

[76] NAE, OGPROF 2/1/1788, pp. 132-33. Leprosy in Ogoja Province: notes of a meeting held in the Resident's Office, Ogoja, on the 28th February, 1940.

[77] Muir (1936), p. 163.

earlier agreements in principle with the RCM, in which the notion that the Native Administrations and the Mission body would share the costs - estimated at around £200 for each party. It was hoped that the relative underdevelopment of Ogoja Province might prompt the British Empire Leprosy Relief Association (BELRA) to provide another £200.[78]

This hope was quickly demonstrated to be in vain - the Nigeria branch of BELRA, meeting on 9th Mar 1940, did not approve a grant to the Ogoja Provincial Leprosy Board on the grounds that a detailed plan of work had not been submitted.[79] In a manner recalling the previous unsuccessful appeals from bodies concerned with leprosy control in Ogoja Province, the problems concerning the working out of detailed proposals in the absence of the expertise of a leprologist and in advance of a survey of the province were raised by both McGettrick[80] and the nascent leprosy board for Ogoja Province.[81]

Finance was not the only stumbling block in the working out of the medical approach to leprosy control in Ogoja in the early 1940s. Legal, political and administrative concerns were also raised by a variety of parties. Some of these were raised by the acting Resident, Ogoja in a letter to the Secretary, Eastern Provinces outlining plans for the province and proposed sources of funding. Known figures for leprosy patients from Afikpo Division receiving treatment from Uburu or Itu were given in the letter. For this number of 1326 patients in total, for whom the Native Administration of the division were fiscally responsible to the tune of at least £220 per annum,[82] it was felt that neither the CSM nor the Native

[78] NAE, OGPROF 2/1/1788, pp. 132-33.

[79] NAE, OGPROF 2/1/1788, p. 148. Memorandum from the Director of Medical Services, Lagos to the Senior Health Officer, Eastern Provinces, Enugu, dated 19th March 1940, endorsed to the Resident, Ogoja on the 25th March, 1940. The endorsement asked that McGettrick be informed of the BELRA decision.

[80] NAE, OGPROF 2/1/1788, pp. 151-52. Letter from McGettrick to the Resident, Ogoja, dated 3rd April, 1940. McGettrick bemoans what he sees as the lack of clarity regarding the Ogoja presentation to the 1940 meeting of the Nigerian branch of BELRA.

[81] MMM archives - 1/Dio/8/3. Letter from McGettrick to Mother Mary Martin dated 8th April, 1940. This letter refers to discussions between the Resident and McGettrick on BELRA's decision - McGettrick comments that 'we are sending a Memo back again to the B.E.R.A. [sic]'. NAE, OGPROF 2/1/1789, p. 184 from the acting Resident, Ogoja to the Secretary, Eastern Provinces, Enugu notes the composition of the Provincial Leprosy Board, comprising, alongside the Medical Officer, two representatives of the RCM (one of whom was McGettrick) and a CSM minister.

[82] NAE, OGPROF 2/1/1789, pp. 198-201. Letter from acting Resident, Ogoja to the Secretary, Eastern Provinces, Enugu dated 6th June 1940. The figure of £220 reflects an estimate of the lowest sum payable by the Afikpo N.A. The figure is derived from references in the letter to a sum of £1 a head payable for each of 88 patients at Itu, and £11 a month payable to the CSM at Uburu for work on roads undertaken as part of a package of treatment for leprosy.

Administration could do any more at present. Balloting all the Native Administrations of the Province, the Resident could only reliably collect £46 of the £200 sought from the Native Administrations for the salary of a leprologist:[83] a submission for £400 had therefore already been made to the Colonial Development Fund.

Two letters from the District Office in Ikom Division make a number of intriguing suggestions regarding cost-effectiveness of various leprosy control measures and the relative importance of leprosy given the amount of money it was proposed to spend. In the case of the first letter, the then District Officer proposed relying on the expertise of Africans in identifying leprosy, rather than hiring a leprologist for the survey, allowing remuneration to be made on a par with 'other assessment clerks'.[84] Further to this, since the correspondent held the problems pertaining to segregation to be of a political and administrative nature, rather than either medical or technical, the need for a leprologist was confined to treatment of serious cases, in the prior event of a successful beginning to leprosy control. These remarks were to be understood in the context of the District Officer's opinion 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'.[85]

Later in the year, the new acting District Officer for Ikom questioned the practicability of employing Native Administration Attendants to treat leprosy, commenting that

> Arrangements involving considerable expense and certainly considerable opposition from the Native Authorities would have to be made for the reception, isolation and possibly housing of leper patients. The Dispensaries would in fact become the local plague spot instead of a Health centre.[86]

and that discipline, policing and cleanliness needed supervision at some expense to ensure proper and effective leprosy control. In contrast with the earlier letter, the potential problems presented by the *fait accompli* of leprosy sufferers seeking treatment are seen to require

[83] ibid., p. 201

[84] NAE, OGPROF 2/1/1788, pp. 146-47. Letter from the District Officer, Ikom to the Resident, Ogoja dated 23rd March 1940.

[85] ibid., p. 147.

[86] NAE, OGPROF 2/1/1789, pp. 216-17. Letter from the acting District Officer, Ikom to the Resident, Ogoja dated 24th June 1940.

concerted political and administrative effort alongside medical and technical intervention. The ongoing tensions between administrative and technical strands of leprosy control policy animated debate on what was beginning to become a serious political problem for colonial administration in Ogoja, with many contending opinions regarding resource allocation and urgency of action.

The growing urgency of the issue was signalled by the circulation of a minute from T.B. Davey, the medical superintendent of the Owerri Province leprosy settlement at Uzuakoli. This minute, circulated throughout Nigeria by the Director of Medical Services in Lagos, concerned legal matters arising from developing leprosy control measures, and was drafted in the first instance by the Resident, Owerri Province. The import of all the proposed legal measures was to 'implement the authority of chiefs, and make that authority effective'.[87] Among the main issues raised included means of restricting movement of leprosy sufferers from an area in which there was no effective control programme to areas where leprosy treatment was available. The influx of large numbers of people from outside the immediate area created difficulties in the exercise of local authority, complicated further by a medical condition which set them outside social norms. Davey notes that chiefs felt this erosion of authority and were in need of guidance on the issue.[88]

A raft of associated measures controlling the movement of leprosy sufferers, proposing continued family and kin responsibility for patients despite their physical isolation from kin groups, and relieving leprosy sufferers of tax burdens were considered useful in setting the scene for the countrywide roll-out of leprosy control services. Though the proposed measures were set out with the Igbo areas of south-eastern Nigeria specifically in mind - due to the dispersed and problematic nature of authority in the area - it was felt useful to circulate the minute throughout the colony, inviting whatever responses might come.

[87] NAE, OGPROF 2/1/1789, pp. 244-48. Circular from the Director of Medical Services, Lagos to the three Secretaries for Northern, Eastern and Western Provinces, dated 11th October, 1941, with attached copy of letter and minute from T.B. Davey to the Secretary, BELRA Nigeria branch dated 4th August, 1941. Endorsed to the Resident, Ogoja Province, 28th October, 1941. The quoted passage is on p. 245.

[88] ibid., p. 246.

The point that legal measures framing leprosy control should not rely on compulsion was taken up in a number of responses made to Davey's suggestions. One response mentioned the importance of propaganda in outlining the reasons why family should continue to be responsible for leprosy sufferers. The respondent also pointed out that the pariah status of a leprosy sufferer was often wielded as a badge of power in acting with impunity, and that dealing with this type of behaviour required strong legal sanction.[89]

A submission from an Igbo respondent, P. Okechukwu, brought attention to the significance of leprosy within Igbo society at this point in time. It was seen to be spreading at a rate that could not be contained by the legal norms of Igbo society, since the leprosy sufferer was beyond legal sanction, by dint of desperation to seek whatever solution might be available in his or her condition. Okechukwu writes that

> [t]he general belief is that a leper may never recover and all things done to him are considered as waste. No law can eradicate this feeling... [The leper] feels he is bound by no law to [pay taxes] for he can neither be sent to prison nor any of his infected properties be seized as a set off.[90]

In his opinion, work on a treatment scheme should precede legal measures, as these measures could only be successful in the context of a control scheme.

Though these exchanges give some idea of the political milieu and policy framework surrounding leprosy control, in the end, any individual measures that were taken owed more to expediency and local developments than to any concerted colonial policy. The context of wartime, though it was not explicitly referred to in official correspondence, caused considerable delay in getting leprosy control in Ogoja off the ground. McGettrick's timetable for the beginning of leprosy work, about which he was in contact with Mother Mary Martin, the Superior General of the MMMs, throughout the early 1940s, was under constant review. He wrote in June 1943 that

> [the g]eneral impression I get is that if we begin all will come in its own time. Let us show something and Government will support. My idea is get Doctor here and two nurses: do a survey and let Doctor

[89] NAE, OGPROF 2/1/1789, pp. 250-51. Response to Davey minute (NAE, OGPROF 2/1/1789, pp. 244-48.) signed and date-stamped 6th Nov 1941.

[90] NAE, OGPROF 2/1/1789, pp. 252-53. Response to Davey minute (NAE, OGPROF 2/1/1789, pp. 244-48.) signed P. Okechukwu and date-stamped 6th Nov 1941. Endorsed with a comment on 'educated African opinion'.

put his scheme on paper. Then we can be strong and demand more support from Government.[91]

The practicalities of travel between Ireland or Britain and West Africa, as well as the difficulties of obtaining imported building materials and cement,[92] slowed proceedings, to the evident frustration of McGettrick, who attempted to find a doctor from a number of sources through 1944. By this time, he had been invited to resubmit the stalled 1940 plans, having been given the understanding that 'Medical and Educational facilities for [Ogoja Province] are the predominant requirements and the authorities are becoming more and more aware of this'.[93]

McGettrick envisaged a Government contribution of about £800, forming a third of the estimated cost of the survey and set-up of a leprosy control scheme in five of the six divisions of Ogoja Province. He wished the doctor and nurses to visit other leprosy settlements in Nigeria to get an idea of the work being carried out, but stressed that he was willing to be flexible as regarded the need for a survey if medical authorities suggested it was not needed.[94] J.W.P. Harkness, the Director of Medical Services for the Government of Nigeria, who was concurrently involved in putting finishing touches to new proposals for the organisation and development of leprosy control in Nigeria and attempting to develop ground rules for the participation of missions in leprosy control work, did indeed propose that leprosy control work in Ogoja go ahead without a survey, writing:

> The organisation of Leprosy work in Ogoja should proceed on the following lines.
>
> (a) Training of European Staff.
>
> (b) Preliminary enquiries by the Leprosy Officer of Medical Officers and District Officers in Ogoja with a study of communications, proposed sites for settlements, clinics and sounding of public opinions through Native Councils.
>
> (c) Experimental small treatment centres to be opened.
>
> (d) If conditions suitable there should be established a Provincial Settlement as a basis for more comprehensive operations.[95]

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[91] MMM archives - 1/Dio/8/8. Letter from McGettrick to Martin. Dated 21st June 1943.

[92] ibid.

[93] Ogoja Convent Files. Letter from the acting Resident, Ogoja Province, to McGettrick dated 14th June 1943. Letter ref. no. OG: 1770/285.

[94] NAE, OGPROF 2/1/1789, pp. 289-91. Letter from the acting Resident, Ogoja Province, to the Secretary, Eastern Provinces, dated 29th June, 1943. McGettrick's reply to letter ref. no. OG: 1770/285 is quoted at length in this letter requesting that the Secretary resubmit the scheme to Government.

[95] NAE, OGPROF 2/1/1789, pp. 296-97. Letter from the Director of Medical Services, Lagos to the Secretary, Eastern Provinces, dated 7th Sept, 1943.

Harkness also attempted to outline what he felt should be the fiduciary responsibilities of both the mission and other bodies party to control efforts (such as the Native Administrations and BELRA), insisting that the mission should be responsible for the financial affairs, transport, training and wages of European staff, and that other bodies could at present be requested to assist with expenses under headings (b) and (c) in the quoted passage.

Harkness' broader proposals for leprosy control in Nigeria were circulated as a paper to those with an interest in leprosy control, and foresaw Government taking responsibility for the most highly developed already existing schemes, whose complexity was now such that it was felt beyond mission capability to run them. This included the settlements of Uzuakoli, Oji River and Ossiomo, in Owerri, Onitsha and Benin Provinces respectively. According to the new plans, a total of almost £35,000 was to be invested in leprosy control in these three provinces in 1944-45.[96] Together with recommendations on the role of Missions in leprosy control, there seemed to be some promise of a small Government grant, though this promise had yet to be fleshed out. This matter was the subject in late 1943 of correspondence between McGettrick, the Resident in Ogoja and the Secretary, Eastern Provinces.[97]

Dr. Harry Hastings, in Uburu, Afikpo Division, had not received a copy of Harkness' paper despite being 'the only person [in the Province] who happens to be doing leprosy work'.[98] He commented that he thought the separation between Government and Mission spheres of competence to be short-sighted. He also expressed the opinion that having started work along

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96 Ogoja Convent Files. Copy of a letter from J.W.P. Harkness, Director of Medical Services, Government of Nigeria to the Chief Secretary to the Government, Lagos, dated 10th Sept, 1943. Paper headed *Proposals for the Organisation and Development of Leprosy Control in Nigeria*, with cost estimates, attached. This letter appears to have been copied for circulation to McGettrick, probably by P.M. Riley, the Resident, Ogoja.

97 Ogoja Convent Files. Letter from McGettrick to the Resident, Ogoja, dated 23rd November 1943. NAE, OGPROF 2/1/1789, pp. 326-27. Letter from the Resident, Ogoja Province to the Secretary, Eastern Provinces dated 26th November 1943. This second letter quotes excerpts from the first letter, referring to it as p. 325 in the same file. Both letters refer to the visit of the Chief Commissioner, Eastern Provinces, to Ogoja, where he had interviewed McGettrick, the Resident and the District Officer, Ogoja (see NAE, OGPROF 2/1/1789, p. 287, 'Extracts from His Honour the Chief Commissioner's Inspection Notes, Ogoja Province, 1st-11th June, 1943'). He found McGettrick to be 'hazy' on the details of his scheme, and the Resident and District Officer to be unsure whether money from the Native Administrations would be forthcoming, but felt that McGettrick's offer to bring out staff should not be disregarded.

98 NAE, OGPROF 2/1/1789, p. 341. Copy of a letter from Dr. Harry Hastings, Uburu dated 13th December 1943. There is no recipient named but the letter was referred to and this copy - presumably - included with NAE, OGPROF 2/1/1789, pp. 338-40, correspondence addressed to the Resident, Ogoja by the District Officer, Afikpo.

the lines already commended by Muir in 1936, and similar in intent to the larger programmes in Owerri and Onitsha, whatever money might become available in Ogoja Province should be granted towards the expansion of his own work, for which he thought the Mission Council in Edinburgh would probably supply another doctor if requested.[99]

In his covering letter, the District Officer for Afikpo stated his opinion that there was call enough within the Province for both the Roman Catholic and the Church of Scotland Missions to become more active in leprosy control. He mentioned the perceived need for another hospital in Afikpo, which the Government did not plan to provide, in the hope that the RCM might begin this work alongside the leprosy work, and mentioned also that Hastings was willing to receive Government aid towards leprosy work, even if he preferred not to receive such aid for general hospital work.[100]

The implications of this for the framing of policy became clearer following meetings in Afikpo and Ogoja in early 1944. The first of these meetings, in Afikpo, was between Mr. Cardale, District Officer, Afikpo Division, Dr. Hastings, Drs. Macnamara and Crabb, Medical Officers for Ogoja and Obubra Divisions, respectively. A number of practical measures were agreed, aiming at getting a leprosy service off the ground while decisions on funding remained to be made. The meeting concluded that there should be only one leprosy service in the Province, with two headquarters and two leprologists, it being assumed that one of these would be attached to each of the missions.[101]

It was also suggested that the present Provincial Leprosy Sub-committee might form the nucleus of a Provincial Leprosy Board as envisaged by Harkness. Funds obtained could then be vested in this Board. It was recognised that transportation would be a major cost, especially since it was seen as more cost-effective to proceed using clan-based settlements, and more desirable to provide small buildings for treatment and seek local land grants for

[99] ibid.

[100] NAE, OGPROF 2/1/1789, pp. 338-40. Letter from the District Officer, Afikpo, to the Resident, Ogoja dated 17th December 1943.

[101] NAE, OGPROF 2/1/1789, pp. 357-60. 'Leprosy in Ogoja Province. Record of a meeting held at Uburu on 30th January 1944.'

segregation purposes, than to build a central settlement at the earliest stage. Given this focus, it was suggested that the Catholic leprologist, once arrived, would spend a considerable amount of the time spent touring other leprosy programmes in Uburu, examining what was being done already in Ogoja Province.[102] The principle of charging a nominal amount for treatment was also raised and agreed, in the context of tax exemption for leprosy patients.

The Ogoja meeting, in mid-March 1944, opened by agreeing that it constituted the meeting of the Provincial Leprosy Board, which the Resident claimed to have been in existence since 1940, and was for all intents and purposes the same as the Sub-committee on Leprosy of the Provincial Development Board.[103] While McGettrick could not yet state with certainty when he would have a leprologist on site due to difficulties in arranging travel permits during wartime, much of the meeting focused on planning for the arrival and work of the RCM leprologist. A series of suggestions made by the Secretary, Eastern Provinces, for the development of a leprosy scheme by the RCM leprologist, were put before the meeting.

A compromise on the issue of the survey was mooted, recommending that the RCM leprologist travel within the Province to form an opinion as to the prevalence of leprosy and to formulate a plan of campaign. The issue of the survey would await soundings on the willingness to co-operate of the Native Authorities, dependent on their perceived need for leprosy control.[104] Hastings agreed with this proposal, seeing no need to carry out a survey which would be essentially unrelated to cure. McGettrick thought that a survey would enable the RCM to establish a centre in the best place, whereas another participant stressed communications and water as vital in choosing the place for a centre. It was agreed to leave the choice to the doctor, McGettrick agreeing to quarter the doctor at Ogoja in the meantime. The opinion of the Board was that leprosy was prevalent enough that clinics opened at any location would be well attended.[105]

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[102] ibid.
[103] Ogoja Convent Files. Minutes of the Ogoja Provincial Leprosy Board held at Abakaliki on March 14th, 1944.
[104] ibid.
[105] ibid.

The recommendations of the Board on how to begin leprosy control was essentially the same as that agreed earlier at Afikpo - that the leprologist should set up clinics first wherever he could. It was felt that clans would, in general, support this approach with grants of suitable land and buildings, and that £200 had already been earmarked by Native Administrations for the RCM leprologist, with a further £300 to be aimed at in the 1944-45 estimates. It was hoped that a call could be made on BELRA funds, given that the Province was left out of the Nigerian scheme. The issue of another doctor at the CSM in Uburu was also raised and left in the hands of Dr. Hastings.[106]

By July, there was still no sign of the chosen RCM leprologist, Dr. Joseph Barnes, being able to secure passage to Nigeria. McGettrick made his concern clear to Martin, writing that his desire to secure the Igbo section of the Province for the RCM leprosy control scheme was threatened by a Protestant doctor's attempt to get a second helper from Europe.[107] This reference to control over leprosy work in Abakaliki Division, contested with Hastings both before and after Barnes' arrival, adds another dimension to analysis of the politics of leprosy control. In a letter written to Barnes, McGettrick was more specific, noting that he would have to give his blessing to Hastings' entry into Abakaliki if he couldn't get a doctor on site first, and that he was therefore thinking of taking a Polish Jewish doctor working at the RCM hospital in Emekuku, Owerri Province (where Barnes had previously worked) on a short term contract to get the work begun.[108]

Shortly afterward, McGettrick was able to send a telegram to Bishop Moynagh in Kiltegan that Lagos had granted travel priority to Barnes.[109] At about the same time, Harkness's intimation while on a visit to Britain that 'the Ogoja proposals were unlikely at present to go forward'[110] discouraged the Church of Scotland from sending out another doctor to the

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[106] ibid.

[107] MMM archives - 1/Dio/8/11. Letter from McGettrick to Mother Mary Martin dated 5th July 1944.

[108] MMM archives - 1/Dio/8/12. Letter from McGettrick to Dr. J. Barnes dated 7th July 1944. Though the handwriting is difficult to read, the doctor's name appears to be either Naidel or Laidel.

[109] MMM archives --1/Dio/8/13. Telegram from McGettrick to Moynagh dated 14th July 1944.

[110] NAE, OGPROF 2/1/1789, p. 397. Letter from Dr. Harry Hastings to the Resident, Ogoja dated 6th November 1944. Harkness spoke to some members of the Foreign Mission Committee of the Church of Scotland, advising them to shelve current proposals to send a doctor to Ogoja Province as leprosy control in the province was not under consideration by BELRA at present, nor had a proper survey been carried out, and there was no leprosy settlement in existence in the province. At a meeting of this committee on 17th July

Province, a fact lamented by the District Officer, Afikpo who outlined the complications encountered in the effort to establish meaningful leprosy control in Ogoja Province:

> The present position seems to be that the Foreign Mission Committee of the Church of Scotland is waiting for us to do something here in Ogoja before they consider sending a doctor to do leprosy work. We here in Ogoja on the other hand are waiting for the Church of Scotland Mission to produce a leprosy doctor so that we can get on with our local plans.
>
> 2. The position seems to be further complicated because the Director of Medical Services [Harkness] wants a leprosy survey done and also no leper settlement for the province is in existence and he thinks this defect ought to be remedied. Here again it seems that the Director of Medical Services will not let the British Empire Leprosy Relief Association funds become available before we have a survey and a settlement, whilst we want leprosy doctors before we can do either and we want financial assistance from the British Empire Leprosy Relief Association in order to get the leprosy doctors.[111]

He concluded that the Director of Medical Services should be asked to specify the terms for release of BELRA funds to Ogoja so that the work of discussing 'ways and means'[112] could be done at the provincial level.

Wartime debates on Nigerian leprosy control in Britain

Harkness' plans were a source of concern to the variety of missionary bodies engaged in leprosy control, and the concerns communicated, both between individual missionaries and between mission and government representatives in Nigeria and Britain, foreshadow many of the efforts made by the RCM in Ogoja to maintain control of its medical institutions. That Protestant missionaries of different denominations were communicating with each other on a wide variety of evangelical and institutional issues is clear from a set of correspondence on Colonial Office and Nigerian Government plans for the Nigeria Leprosy Service, forwarded on behalf of H.D. Hooper, the Africa Secretary of the Church Missionary Society in London, to JWC Dougall of the Church of Scotland Mission in Edinburgh.[113]

1944, it was 'decided to defer consideration until the scheme was further matured'.

[111] NAE, OGPROF 2/1/1789, p. 389. Letter from the District Officer, Afikpo to the Resident, Ogoja dated 4th December 1944.

[112] ibid.

[113] National Library of Scotland. Manuscript Collection. Church of Scotland Foreign Mission papers. ACC 7548 – C 82 – A/132. Letter from Ruth Allcock, Secretary to H.D. Hooper, Africa Secretary, Church Missionary Society, to JWC Dougall, dated 21st June, 1944, enclosing letters from Hooper to Dr. Kauntze at the Colonial Office, and Dr. Chesterman of the Baptist Missionary Society, from Mr. Cohen at the Colonial Office to Hooper (a copy of which was also sent by Cohen to the Methodist Missionary Society), and a report on Oji River Leprosy Settlement by Dr. H.G. Anderson.

Their concerns were expressed in a nutshell by Dougall, writing to Harkness in summary:

> ..it seems to me that you have not found the best place for the medical missionary in the plan. The contribution of the missions in leprosy-work has been notable in India and Africa for three main reasons: (1) it has attracted a number of first-rate men who gave themselves to work among lepers in the spirit of Christian vocation; (2) it has built leper-colonies into the larger life of a Christian community and stressed the positive social habits which enable the patient to recover self-respect and hope and purpose in an atmosphere of fellowship; (3) it has given the doctor-patient relationship a more personal character, enabled the missionary to practice his medicine in the name of and for the sake of His [sic] Master, and thus inspired more confidence and trust on the part of the patient.[114]

This note of concern had been prompted by the intensive debate on which Hooper had invited Dougall's judgement. Hooper acknowledged that the legacy of previous European missionary attempts to combat leprosy may have given rise to fear and misapprehension, but at the same time he pronounced himself 'concerned to secure that the fullest goodwill of the Churches and of the mission agencies is marshalled behind the new [government leprosy control] experiment.'[115] In his letter to Dr. Kauntze at the Colonial Office, Hooper posed a number of questions about the new proposals for leprosy control in Nigeria, shedding light on missionary preoccupations and reflections on colonial institutional structures.

Doubting the value of hybrid mission-government institutions as effective means of securing cooperation, he queried whether the Government's plans, conceived out of a new-found recognition of its responsibilities with regard to leprosy control, were actually designed with the securing of the fullest value of voluntary agency contributions in mind. Further, he wondered whether the proposals are dependent on the 'outstanding personalities at present occupying the responsible posts', and whether new responsibilities and relationships could be accommodated within the structures. Finally, he wondered whether assent to the terms of the Nigerian experiment would commit Churches to acceptance of similar proposals in other colonial territories, fearing that 'the blueprint for one Colony or Protectorate is often broadcast before it is possible to form a judgement as to the reliability of the design'.

Writing to Dr. Chesterman of the Baptist Missionary Society, Hooper confided the concern

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[114] National Library of Scotland. ACC 7548 – C 82 – A/132. Letter from JWC Dougall to Harkness, dated 11th July 1944

[115] National Library of Scotland. ACC 7548 – C 82 – A/132. Letter from H.D. Hooper to Dr. Kauntze dated 13th June, 1944.

which animated his queries of the Colonial Office, that the churches might be 'rushed into a scheme the details of which might prejudice our missionary purpose and defeat the ends in view, viz. a free cooperation of Church and State in this new experiment'. Concerned to present a united front among the Protestant mission societies, Hooper noted that

> while recognising the variations in relationship with the three big centres of Itu (Dr. MacDonald of the Scotch Mission), Uzuakoli (Doctor Davey of M.M.S.), and Oji River (Dr. Money of C.M.S.) I felt that the Churches could not be content to negotiate separately and independently with the Government as to the extent and character of their cooperation, since such cooperation involved some fundamental principles of mission work.[116]

He contended that Harkness, though appreciative of the value of religion in his leprosy control proposals, misunderstood the reasons behind the heritage of missionary success in missionary control. He claimed that this heritage derived from

> not only the personal ability and character of the several missionary doctors but the fact that the communities in which these settlements were integrated are Christian communities and have given their leper inmates a new sense of social entity and of self-support.[117]

and that the advantages derived from mission status might be weakened by expecting doctors to become government officials on full salary. Attesting that the basic maintenance rates the missionaries draw are an asset in relations with Africans which it would be better not to blur, Hooper all the same implied that the continued intimacy of settlement and church need not undermine the aim of overall government control and direction of standards and progress regarding leprosy control. Though he agreed that if necessary Money, the Church Missionary Society medical superintendent at Oji River, would be released to Government service to become medical officer in charge of the Nigeria Leprosy Service, he wrote, in a final salvo across the bows of the Colonial Office, that he had 'used “Mission” and “Church” indiscriminately in these notes because the differences are not yet apparent to the officials of the Colonial Office'.

In a clarification on the status of staff and the division of administrative duties regarding government leprosy settlements,[118] aiming to dispel the darker suspicions of British-based

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[116] National Library of Scotland. ACC 7548 – C 82 – A/132. Letter from H.D. Hooper to Dr. C.C. Chesterman, dated 19th June, 1944.

[117] ibid.

[118] This is the terminology in use in the correspondence quoted here – the more comprehensive term, 'scheme', is not used.

missionary administrators, A.B. Cohen wrote to Hooper, and to the Medical Secretary of the Methodist Missionary Society[119] that the duty of medical and European nursing staff employed at the leprosy settlements under government control would be to the Nigeria (not the Colonial) Medical Service, though such staff would not be expected to sever their ties with their Missionary Society; nor indeed would this be seen as desirable. In the appointment of new staff, the Secretary of State would consult missionary societies for candidate recommendations, and in any case, would seek to employ someone who would be able to work in close cooperation with these societies, which would continue their charge of educational, social and welfare elements of the settlement, with appropriate staffing, freeing the medical staff to work exclusively on medical duties.

However, the notion that the spheres of medicine and spirituality achieved a unique and powerful symbiosis in missionary hands was again propounded in a determinedly missionary, as opposed to medical, interim report on the Oji River Leper Settlement presented at Lagos and copied to Hooper. In this report,[120] Dr. H.G. Anderson of the Church Missionary Society complimented the achievements of the Settlement in often contradictory fashion, likening it to 'a highly specialised form of the old Abbeys at their best', dramatising a Christian emphasis on gathering the less fortunate together to share in the protection of the Church, and denoting an almost limitless potential for fulfilment of missionary aims. Lauding its air of permanence from both spiritual and material points of view, he proclaimed its deep-rootedness in African soil and its full use of Africans and missionary staff, while bemoaning the lack of rootedness in the 'soil of [its] English home constituency' which drove it to dependence on Government for further developments and expansion.

Anderson called for a diversification in the responsibilities of the missionary staff of the Settlement to accompany its expanding scope and complement of clinics, each of which should be inseparable in spirit and inspiration from the parent. Conceiving of a pattern of

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[119] National Library of Scotland. ACC 7548 – C 82 – A/132. Letter from A.B. Cohen, Colonial Office, to Hooper, dated 19th June, 1944. The writer noted that an identical letter was being sent to the Methodist Missionary Society.

[120] National Library of Scotland. ACC 7548 – C 82 – A/132. 'Interim report on the Oji River Leper Settlement, Nigeria', by H.G. Anderson, dated 5th June, 1944.

organic growth in which the challenge of manifold responsibility represented both spiritual success, and an encouragement to the African Church to realise a vision 'of the spiritual care of those attending for treatment and in the rehabilitation of those returning cured to normal village life', Anderson claimed to thereby identify the weakness of government plans for a Nigeria Leprosy Service. Fearing that the government 'does not realise its incompetence to make the spirit of Oji River part of a wider state scheme', he indicated his distrust of lavish spending without an agreed policy of non-interference with religious and missionary sensibilities.

In support of his thesis, he cited the long English Christian tradition as crucial in the development and maintenance of medical services, and the role in Russian medical success of the 'almost religious nature of Communist drive'. He counterpointed this with the spiritual aridity and consequent failure of medical services in Africa, in spite of the best of government intentions, and proposed an intermediary and independent Central Leprosy Board to oversee co-operative structures to supervise standards, budgets, local and provincial schemes and relations with external bodies maintaining an interest in leprosy.

Though the leap from spiritual exaltation and magnificence to administrative and bureaucratic minutiae is surprising, it does catch much of the flavour of the emerging modus operandi on religious and missionary engagement in imperial welfare projects, underlining the increasing complexity of both forms of interaction with colonial populations, and finds echoes in the theory and praxis of Catholic mission evolved by McGettrick and the Kiltegans, Joe Barnes, and the MMMs.

Throughout the correspondence forwarded by Hooper to Dougall, the plans for leprosy control were tantalisingly referred to as an experiment. Hooper's aide-memoire on the meeting of interested parties at the Colonial Office on 20th July 1944[121] for a discussion on leprosy in Nigeria brought out some of the more important points of contention between government and missionaries, characterised as representing authoritative and voluntary

[121] National Library of Scotland. ACC 7548 – C 82 – A/132. 'Notes on "leprosy" discussion at Colonial Office: an aide-memoire and not a record', Dated 20th June, 1944 and initialled HDH.

principles of service respectively.

It was agreed that the existing BELRA Nigeria committee would be best placed to act as a statutory leprosy advisory board, constituted similarly to Educational Advisory Boards in that all co-operating bodies would be represented. Though the missionaries felt that the comparison of the experiment in co-operation suggested in the case of leprosy control to the experience in the field of education, where control over contracts and expansion remained in the hands of missionaries subject to inspection along the lines of government-mandated standards, obviated the need to transfer missionaries engaged in leprosy control to government service. Harkness countered that the experimental character of the suggested innovations in leprosy control, amounting to 'an intensive, and therefore limited, field experiment in the eradication of the disease', necessitated complete clinical control on the part of the Medical Department, which required that missionary medical staff be seconded to the Department.

The missionaries exacted some compromises in principle, facilitating, for instance, the retention of mission status by staff who paid the difference between government and mission salary rates into a pool for discretionary expenditure on leprosy work, and retaining control over the deployment and location of mission staff. Crucially, for the Church Missionary Society, an agreement was reached over the Mission's lease at Oji River, detailing compensation due in the case of terminated co-operation, rights to buildings, and duties to leprosy work over all other works that might be carried out on site. These principles agreed, and plans in place for a five-year term of co-operation in the first instance, it would be incumbent on the mission societies to acknowledge the claims of the leprosy service in their recruitment and funding propaganda, and to discuss any expansion of leprosy work with the Director of Medical Services.

For BELRA, this completed a transformation based on marrying insights garnered from Leonard Rogers' experience with the effective non-segregated treatment of early cases of

leprosy at dispensaries in India, South Africa and the South Pacific,[122] and Muir's observations of the success of clan-based settlement schemes in Uburu and Oji River in Eastern Nigeria in the 1930s. These insights and observations were elaborated into a preferred programme for the extension of leprosy control amid the political and social circumstances of colonial Nigeria, which was in essence that adopted by the nascent Nigerian Leprosy Service after 1945. BELRA acted both as a de facto government advisory body and as a grant awarding body in the early years of the functioning of the Nigerian Leprosy Service, thus confirming through its quasi-formal role in Nigeria the imperial remit of its title, and cementing its influence of Nigerian, and by extension, African leprosy control politics over the next generation.

Framing proposals for RCM leprosy control - Ogoja Province, 1945

By this stage Dr. Barnes had arrived in Nigeria, and by early January 1945 he had toured the already existing leprosy centres in Eastern Nigeria and was at work in and around northern Ogoja Province.[123] He had also prepared a paper detailing his proposed approach to leprosy control in northern Ogoja Province, which was presented to and discussed at the meeting of the Ogoja Provincial Leprosy Board held at Abakaliki on 24th January 1945. His presence and his paper helped immediately to give some clarity to previous and ongoing discussions about leprosy in Ogoja.

Barnes' proposals envisaged the Ogoja Provincial Leprosy Scheme as an adaptation of the Nigerian Government proposals, and thus as a descendant of the Muir report of 1936 and a relative of the Owerri and Onitsha Province schemes, modelled to some extent on Hastings' work since 1928 in Uburu. Holding that 'the control of leprosy depends on the isolation of all

[122] Leonard Rogers, 'Light in the darkness', in *British Empire Leprosy Relief Association. Annual Report*, (1949), pp. 4-5.

[123] MMM archives - 1/Dio/8/16. Letter from McGettrick to Miss J. Powell, Dublin dated 26th January 1945. NAE, OGPROF 2/1/2861, p. 17 relates that Barnes' tour of the other leprosy settlements lasted three months. From his own notes in the Ogoja Convent Files on village visits in Ogoja Province, it is clear that he was already engaged in this work by January 5th, 1945.

infectious cases',[124] the scheme resists the notion of home segregation of patients and insists that leprosy control must be universal for the area of coverage. Building on this principle, the design of the scheme purports to completeness and effectiveness through the offices of a variety of institutions, staff and infrastructural supports, and propaganda.

The institutional differentiation posited by the scheme envisages the scheme's physical instance as an instrument of isolation to be separable into leper hospital, leper village, leper asylum, and the home. Each would have its own function in the project of leprosy control. Barnes writes on each:

> The leper hospital is intended for those lepers requiring operative or highly skilled Medical treatment... The leper village is for the isolation of infectious cases. It is really the backbone of the whole organism... Home isolation will be used for non-infectious cases. The leper will have his own house in the compound, his own utensels [sic], and bed clothes, and keep away from all children... The leper asylum is for the incurable cases. It will be supported and limited by charity.[125]

This schematisation was expanded to consider effective deployment of staff and resources, the geography and politics of site selection, and the typology of buildings and other infrastructural elements.

Though the financial estimates presented as part of Barnes' proposals provided for one European Doctor and four European Sisters, the proposals themselves envisaged a medical staff of two, complemented by a nursing staff of two, a laboratory technician and clerks.[126] In his formal consideration of the roles of each of these members of staff, he envisaged a senior medical officer resident at the headquarters of the programme, seeing to the patients in the hospital and the 'model village', trying out the best treatment available and reporting to the Senior leprosy Officer, Lagos. The junior medical officer would be responsible for new cases in the isolation villages and as cover for the senior medical officer. The Sisters, both trained nurses, would be responsible for training African staff for the maintenance of isolation villages and for hygiene in the villages, but would reside apart from the village itself in order to underpin the isolation rule of the scheme as a whole. Barnes also envisaged a large

[124] Ogoja Convent Files. 'Leprosy in Ogoja Province', by Joseph Barnes. The version of this document in the Ogoja Convent Files consists of ten typed pages and seems to be the most complete copy of the proposals.
[125] ibid., pp. 1-3.
[126] ibid., p. 2.

African staff as the 'privates' of the leprosy control 'army', responsible for injections, record-keeping and reporting.[127]

The issue of propaganda also received detailed consideration, reflecting a careful blend between medically-inflected exhortation, examples of cure, and religious and pastoral intervention. The principles taught at HQ were to be disseminated among the general populace of Ogoja, and the gratitude of the cured leper was seen as one of the most powerful weapons in the propaganda armoury. Land, labour and compulsion regarding the issue of case isolation were important issues to be brought to the attention of the local leadership - the District Officer was seen as the second rank in the enforcement of local co-operation once this was secured in theory by the principal medical officer. The Sisters, through the mechanism of education and women's meetings, would see to it that the importance of adopting and caring for the children of lepers was appreciated at a local level, while the priest would counter local religious beliefs, whether Christian or traditional, on the stigma associated with leprosy. It was envisaged that this campaign would be ongoing and repeated.[128]

Though the scheme was elaborate, Barnes saw it as scalable, if the growth was carefully planned. The foundation of a hospital, an accurate survey, and the creation of an asylum would follow the provision of adequate local treatment, building on the knowledge and co-operation of local officials and leaders. Local communities would be habituated to the presence of the leprosy medical staff and the religious Sisters, and thus the scheme would grow. In Barnes' words

> The rate of... development will depend on the two factors, the enthusiasm and number of the staff and the reaction of the people. The rates will therefore fluctuate as every natural growth does but it is strongly felt even as in nature the first year should be the time of greatest development.[129]

Objections from members of the Provincial Leprosy Board were anticipated, and dealt with in the proposals themselves. The absence of proposals for a farming colony, as at Itu, was explained with reference to the high cost and great administrative overheads associated with

[127] ibid., p. 4.
[128] ibid., pp. 5-6.
[129] ibid., p. 8.

such an undertaking, and the impracticality of a complete leprosy survey was reiterated, stressing that 'it would scarcely be fair to ask any man to spend two years counting lepers as has been suggested'.[130] The scheme was defended as cost-effective, and undemanding with respect to the public purse, and the charge that it might be over-elaborate was rebutted with reference to its 'tribal independence which will save it from the danger of statism'.[131] The development in due course of more than one hospital to meet needs as they might arise was allowed for within the outlines provided, and the charge that the proposed administrative and treatment centre at Abakaliki, seen as best suited from a population and European perspective,[132] would be too close to Afikpo was derided as counter to existing systems of local administration.

In a forerunner to his later ideas on rural development, Barnes presented his proposals as forming a whole, writing:

> For purposes of description the plan had to be analysed and divided into parts but we wish to emphasise that it is a simple organic unit, an organism rather than an organisation, having all the features of such a body: growth of villages and reproduction in other clans. Nor is it without a vivifying principle.[133]

All the same, critique would be focused on specific issues, as was demonstrated at the January 1945 Ogoja Provincial Leprosy Board meeting. Barnes had enjoyed the co-operation of the various schemes he visited while formulating his plans, but the intricacies of securing assent from local administrators and missionaries of other denominations were somewhat more tortuous.

Regarding the issue of demarcation between missions, each, in theory, subject to the overarching supervision of the Provincial Leprosy Board, it was decided to adhere to existing administrative boundaries rather than dividing Abakaliki Division between the two missions. This outcome pleased the RCM, as it sidelined Hastings' contention that the populous, Igbo-dominated Ezza and Ikwo clan areas of southern Abakaliki Division constituted a natural hinterland for the CSM Uburu site and were seen as crucial to its eventual success.

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[130] ibid., p. 9.
[131] ibid.
[132] ibid., p. 2.
[133] ibid., p. 10.

Evidently, poor communication between the CSM at Uburu, Harkness and the Church of Scotland Foreign Mission Committee in Edinburgh had led to the impression that no government support for voluntary agency leprosy control in Ogoja Province could be provided, and that therefore it was not worthwhile to send a full-time leprologist to Uburu.[134] It is clear from the minutes that the presence of a dedicated leprologist shifted the debate on demarcation in favour of the RCM. As a result, the RCM sphere was to include Abakaliki and Ogoja Divisions and Obudu District, while the CSM would take charge of work in Afikpo, Obubra and Ikom Divisions, the latter of which was largely cut off from the rest of the Province and was envisaged as remaining so for a number of years to come.

Though the relative fortunes of the two schemes, that of the RCM in northern, and the CSM in southern Ogoja Province, would lead to the ceding of coverage for Ikom Division to the RCM in later years, the fixing of borders at the 1945 meeting forestalled any serious friction or territorial wrangling between the two missions over the subsequent decade. The most significant source of competition between the two missions took shape as a comparative bargaining process, set in train by the complex and endlessly mutable funding arrangements to which the leprosy schemes were subject. Some impression of the jockeying which would take place, both between the missions, and in relation to ongoing bargaining with government (at national, regional and county/native administration levels) and with BELRA, can be gleaned from the 1945 meeting, where a division in principle is made between headings to be funded by missions (costs associated with expatriate staff, including salaries, passage, housing, and equipment), BELRA (equipment for clinics, drugs and dressings, vehicles, and African staff wages), and the relatively impoverished Native Administrations (running expenses, vehicle maintenance). There divisions were variously contested and shifted over the next years, and became crucial in the working out of mission, government and local spheres of influence.

[134] Copies in Ogoja Convent Files and NAE, OGPROF 2/1/1790, pp. 400-03. Minutes of a meeting of the Ogoja Provincial Leprosy Board held at Abakaliki on January 24th, 1945. The two versions differ slightly but both mention the decision of the Foreign Mission Committee of the CSM not to send a second doctor to Ogoja - a mention of the Board's deplorement of this is crossed out in the National Archive, Enugu version and is entirely absent from the Ogoja version.

1945 – leprosy control in transition

The period described in this chapter represents a transitional moment in the history of leprosy, marking the last period in which there could be commonly held to be no effective cure for the illness. The therapies used and developed over the previous fifty or so years relied on evolving institutional constraints focused on the delivery of a largely ineffective remedy to a segregated and more or less captive population. The remedy in question was chaulmoogra oil, a derivative of the oils of the hydnocarpus tree, and its supposed efficacy seems to have owed as much to the institutional strategies evolving in the mid-twentieth century dedicated to early case discovery, the social care techniques employed among segregated populations, and the slowly increasing funding and medical attention available for these communities.[135]

This period, then, amounted to a high-water mark in the refinement of social, rhetorical and technical strategies of segregation in leprosy control. It was framed in the context of Nigeria by the agreement by the colonial administration to spend substantial funds on welfare and development, and preceded the race to isolate, test and standardise chemotherapeutic agents, leading to the definitive adoption of dapsone[136] as the agent of choice for the treatment and cure of leprosy subsequent to the Havana International Leprosy Congress of 1948. The RCM Ogoja leprosy scheme was conceived and implemented amid the promise of development bounty, begun in earnest during the last months of World War Two in early 1945, and carried through in an isolated area with a particularly high prevalence of leprosy: thus it is perhaps no surprise that it should embody many of the salient features, as well as the tensions and problems of the segregation-based approach to leprosy control.

Though many crucial decisions influencing the shape and development of leprosy control in Ogoja Province had been made prior to Dr. Joe Barnes' return to Nigeria in late 1944, it was

[135] J. Iliffe, (1987), p. 225.
[136] See Chapter Six.

the arrival of Barnes, and the subsequent engagement of three MMM Sisters, which crystallised the nebulous array of previously mooted schemes and promises. The appeals made by Mgr. Thomas McGettrick in The Medical Missionary of Mary over the previous four years at last took on an institutional footing which enabled the translation of ideological musings and theories of charity into a series of practices which focused the notion of Catholic mission, developing practical concomitants by which the success of Christian charity could be measured and advertised, and the stability and extent of Catholic conversion supported and policed within the defined boundaries of 'African' leprosy villages.

The decision by Dr. Joe Barnes to proceed along the lines of the clan village scheme for leprosy control, allied with the perceived impracticability of carrying out a full survey of the population to determine the prevalence of leprosy, effectively codified existing anthropological knowledge, itself scant with reference to the eastern half of Ogoja Province, into the ordering and administration of leprosy settlement and segregation villages. For missionary personnel, the years between 1936 and 1945 were characterised by the need to rapidly assimilate the bureaucratic and managerial techniques which would convince government of the seriousness and competence of missionaries as potential providers of colonial welfare services.

This left the RCM in a markedly different strategic position with regard both to the colonial administration and to African communities than that which it occupied at the time of Mellett and his confreres. Amid the wrangling over finances, spheres of influence, and the scope for evangelism, the Catholic Church could no longer pretend to innocence with regard to its implication in colonial mechanisms of control. While it could claim not to be interested in local politics for its own sake, close co-operation with colonial officers at district and regional levels operationalised colonial intelligence into missionary practice.

The attempts made by the Catholic mission to achieve equality of esteem with other missionary bodies in the dispensation of BELRA funding involved it in much the same debates as British mission bodies, more conscious of and at ease with their relations with the

Colonial Office. The confluence of a growing Catholic missionary presence on the ground in Ogoja, the belated recognition on the part of the colonial administration that leprosy would need to be formally managed within the boundaries of the Province, and at a local level, and the availability of new sources of funding for welfare work brought about a situation in which the RCM was placed at the forefront of collecting and defining 'colonial' knowledge about Ogoja, and would come to play a vital part in determining its interaction with Nigeria and with the world at large in the late colonial period.

Map 7: RCM-administered leprosy control area (including Ikom from 1951)[137]

[137] Nigeria, Survey Department, *Nigeria Eastern Region*, 1:750,000, (Lagos, 1952).

Chapter Four - Leprosy control and the development of Catholic and mission identity in Ogoja

> True friendship permeates this isolated community, and happiness and peace come to the lepers, for as the evening brings cool breezes after the tropical heat of the day, so the presence of the medical missionaries brings tranquillity to the sufferers.[1]

Prior to their arrival in Ogoja in April 1945, the notional position of the MMMs in the planned RCM Ogoja leprosy scheme had been delineated by McGettrick in a variety of articles, and suggested in correspondence both with Martin in Ireland and with relevant government and medical officers in Nigeria. While superficial accounts of MMM practice in Ogoja corroborated McGettrick's reading of their place within the leprosy scheme and the mission more broadly, MMM reflections on the experience of day-to-day administration of the RCM Ogoja leprosy scheme unveiled a more nuanced internal politics of mission, expressed in discourses of work, prayer, travel, community and healing. The differing interpretations of mission among male and female religious and lay missionaries produced an intense and layered set of intellectual meditations on the nature of Catholic medical and spiritual labours in Ogoja, continually contextualised by broader trends in Catholic mission and spirituality. This discourse further served to shape the parameters of mission encounters with Africans, with the missionary as balm, as exemplar, and as a symbol of the redemptive power of Christ.

In his missiological interrogation of healing and medicine, Christoffer Grundmann posits the existence of 'a broad variety of arguments to justify the employment of the healing art as a means to an end [in] the missionary enterprise.'[2] Contrasting the *imitatio Christi* common to Protestant missionaries and some Catholic theologians, with the *imitatio Mariae*[3] seen as

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1 Script excerpt from *Visitation: the Film Story of the Medical Missionaries of Mary*. (16mm film, 1948: reissued on VHS, 1999)

2 C. Grundmann, 'A powerful means to an end? Healing, missiologically interpreted', in Pirotte, J and H. Derroitte, eds., *Églises et Santé Dans le Tiers Monde: Hier et Aujourd'hui: Churches and Health Care in the Third World: Past and Present*, (Leiden, 1991), p. 170.

3 ibid. Imitating Christ is portrayed as 'bringing relief to the disease-ridden peoples', while imitating Mary signifies 'bringing Christ into the world like Mary did.' This distinction resulted in divergent interpretations of relations between healing and redemption among practitioners of mission medicine, with Catholics inclined to posit an interceding role for Mary in relating Christ to the work of the Church. In Grundmann's

native to Catholic female medical missionaries, and to some extent, to the generality of Catholic missionaries, Grundmann claims that the latter spiritual practice guards against the simplistic identification of scientific and curative biomedicine with Christ's healing power, shifting the emphasis from healing to redemption. In his analysis, he explicitly associates *imitatio Mariae* with the Medical Missionaries of Mary[4], tacitly acknowledging the sheer ideological energy and productivity of this congregation which had, in a short time, positioned itself at the centre of mid- to late-twentieth century Catholic reflections on the links between spirituality and medicine.

In the period between 1945 and 1960, Ogoja and leprosy control were paramount in the promotion and development of the MMM missionary identity, forming the centrepiece of the widely-screened documentary *Visitation: the Film Story of the Medical Missionaries of Mary*, and generating a powerful visual and narrative armoury for public display and consumption, as evidenced in numerous issues of the congregation's eponymous periodical. In this chapter, I examine the central components of the process of mission identity formation in the first years of the RCM Ogoja Leprosy Scheme, paying specific attention to the outlining of an ideal rule for daily living, the specification and gendering of roles and duties in concert with efforts to manage increasing organisational complexity, the foregrounding of the Marian ideal in the making and dissemination of *Visitation*, and the fostering of an affinity with the mission territory of Ogoja through the embodiment of sacrifice as martyrdom.

Constructing an exemplary daily life

The outlines of MMM discourse on mission and leprosy control are laid out in a composite internal document produced in February 1945, before the arrival of the first MMMs in Ogoja, setting out an horarium or timetable, and guideline regulations for Ogoja Convent.

analysis, *imitatio Mariae* forestalled the theoretical descent into 'religious imperialism' by sundering the explicit link between the performance of a medical cure and the power of the Christian deity.

4 ibid.

Interspersing medical and spiritual duties with mealtimes, recreation and siesta, under the rubric 'Idleness is an enemy to the Soul',[5] the regulations counselled moderation, a sense of duty, and an obligation not to 'disturb' one's colleagues. With regard to the balance between work and recreation, while the need to timetable recollection and rest was noted in an appendix to the horarium, it was further emphasised that

> [t]he needs of our Mission and our Spirit of Poverty will oblige us to Work [sic] hard, let us not be saddened thereat but rejoice, praise God because then we are... truly religious when we live but the labour of our hands, as did Our Divine Lord, His Blessed Mother & the Apostles.[6]

As well as establishing the centrality to MMM self-perception of the valorisation of 'Work', the obligation to monitor and moderate behaviour as an aid to community and spiritual life, and the discretionary power which mediated the breach between the demands of medical and hospital practice and the spiritual life, the horarium set out the patterns through which convent daily life would be instantiated into the life of the leprosy village. Hospital duties would occupy all Sisters until 1 p.m., and again in the early evening, while the afternoon brought a round of social work duties, specified and listed as 'Visit marriage quarters, Cathechetical work, Legionary meeting & mothers [sic] meetings.'[7] While this list anticipated rather than prescribed the potential layout of the leprosy scheme, it also prefigures an interpretation of women's work aligned to a long tradition of female missionary engagement.

Alongside this outline of how the day should be approached and divided was a set of instructions on the compilation of sacred returns relating to the medical work carried out in the institutions entrusted to the MMMs. A tri-monthly statement of expenditure, a twice-yearly statistical return to the MMM Superior General in Drogheda, and an annual return to the Bishop of the Vicariate in which the Convent was situated would be made out and filed. These returns separated out income from expenditure, each comprising a variety of headings

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5 MMM archives - 1/Fou/4(n.1)/1. Horarium and regulations for Ogoja Convent, dated 2nd February 1945.

6 ibid.

7 ibid. 'Legionary meeting' refers to the Legion of Mary, a lay Catholic organisation founded in Dublin in 1921 by Frank Duff. Modelled on the St. Vincent de Paul Society, and organised along the lines of the Roman Imperial army, it blended social action and prayer, and was introduced to Africa by James Moynagh in 1933. See *Symposium on the Legion of Mary*, [1957?] for further details on the history, ideology and expansion of the Legion.

relating to convent and hospital expenditure, donations, fees, and grants. The number of Sisters, doctors, patients and staff in the hospitals was also to be collected, as were figures on births, training, and examination results. The blending of accountability and responsibility, assumed by the MMMs in this composite text, set the tone for contending notions on proper spheres of influence in the management of the RCM Ogoja leprosy scheme.

The calm tenacity prefigured in the horarium and regulations dissolved at once in the whirlwind surrounding the arrival of the first three MMM Sisters in Ogoja in April 1945. Srs. Aloysius [later Teresa] Connolly, de Lourdes Gogan and Philomena Doyle arrived via the existing MMM Convent and hospital in Anua, to find Mgr. McGettrick anxiously preoccupied with the provision of accommodation for the Sisters. McGettrick's own recollections, over forty years later, capture some of the confusion attending a new missionary enterprise:

> I can never forget the week before the Sisters arrived. We had no Convent built for them. All we had was a mat roofed house... We had just part of the house roofed [with zinc] when their arrival on Good Friday was announced... The Sisters arrived in Enugu. - a nurse, a secretary and an occupational therapist... Each of them carried a valise and gave me a hearty handshake. What happy, smiling faces! But they gave me a nasty jolt when they informed me that they left their luggage at the Anua Hospital. They had no dresses except what they had on... I informed them that we would supply priests' soutanes to cover their nakedness while the one outfit they had was being washed... They laughed and did not blink an eyelid... The Sisters were handy with the needle and transformed old soutanes and 'hand-me-downs' bought in a local market into something fantastic. Their luggage from Anua arrived one month later.[8]

The account offered by Sr. Aloysius Connolly in her first letter from Ogoja to Mother Mary Martin in Drogheda differs somewhat in emphasis. McGettrick's solicitude is gratefully lauded, though it is clear that some luggage travelled with the Sisters,[9] and that the greater call on their resourcefulness was made by the duty roster outlined by Barnes. From the outset, a series of responsibilities had been envisaged for the MMMs, and these were apportioned according to the perceived qualifications of the individual Sisters. Sr. Aloysius

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[8] McGettrick (1988), pp. 202-03.

[9] MMM archives - 1/Fou/4(n)/1. Letter from Sr. Aloysius Connolly to Mother Mary Martin, dated April 1945, mentions practical problems with changes of clothing while at work, noting that grey gowns are used at the clinic, the Sisters changing into whites on their return to the convent. A request is made for more whites, but no inkling of the domestic inventiveness so keenly remembered by McGettrick is to be seen. McGettrick himself notes in a contemporary account (MMM archives - 1/Dio/8/17 - letter from McGettrick to Mother Mary Martin dated 9th April 1945) that 'they have not yet got their loads but I think they are happy'.

wrote:

> You would be highly amused to hear Sr. de Lourdes when [it was] announced that she was to give lectures to future nurses or as Dr. Barnes christened them Leper Control Officers... Sr. Philomena is also starting lectures on Hygiene and Sanitation to the Nurses... My chief work here is office work when I am not out in the Bush... Sr. de Lourdes has the clinic here and the training the nurses. Sr. Philomena is chief Propagandist.[10]

In this letter, Sr. Aloysius articulated an initial hint of scepticism regarding the scale and complexity of Barnes' plans and a curiosity aroused by the unusual terminology and ritual of leprosy control, alongside a sense of panic regarding the scale and intensity of the labours ahead. Asking that their 'escapades' be related to some of the Sisters in Drogheda, she wrote 'ask them to please pray extra hard for us as we are so unworthy and so incapable of this work'.[11]

At the same time, the excitement of beginning the work in the name of God was magnified by the welcome ceremony which greeted the MMMs first Sunday in Ogoja, with oratory from McGettrick and Barnes, a delegation of local personages, and a rendition of 'It's a long way to Tipperary' by the School band. We are told that

> Sr. de Lourdes after a little coaxing from Monsignor got up to thank the people for their welcome and ask them for their prayers and co-operation in her own concise way. [Barnes] said how few were the words recorded in the Gospel by Our Blessed Lady they were all summed up in the Magnificat. He wanted to bring out how much like Our Lady she was.[12]

The insertion of such a deliberately feminised discourse into the idealised project of Catholic leprosy control was of primary importance in the ideological labours of Barnes, McGettrick and Martin over the following years.

A Sister's work on a medical mission

Managing a fledgling leprosy control service

The tone of the Mission's approach to the provision of leprosy services had already been

[10] MMM archives - 1/Fou/4(n)/1. Letter from Sr. Aloysius Connolly to Mother Mary Martin, dated April 1945.
[11] ibid.
[12] ibid.

signalled in the report on a meeting of RCM medical officers, matrons and Sisters in Southern Nigeria held at Emekuku, the site of a Holy Rosary Sisters' hospital in Owerri Province, in December 1944. It was specified that the doctors employed should be 'Catholic, qualified practitioner[s] of medicine and of good health',[13] while the importance of specific training in tropical medicine was downplayed, its necessity being linked to the length of term of service undertaken.

The informality of the proposed relationship between the Doctor and the Mission was indicated by divided opinion on the desirability of a contract. The interpretative reflection on this issue generated a series of meditations on the roles of men and women in Catholic medicine, and on the personality of the 'Missionary doctor', whose 'generous and self-sacrificing spirit could be maintained by a gentleman's agreement', the spirit of the doctor obviating the need to detail the terms of agreement. The notions of zeal and sacrifice were also invoked with reference to propaganda, it being supposed that the doctor would send articles and photographs to missionary magazines in order to excite the generosity of Irish doctors in response to personal appeals, short-circuiting the requirement to maintain specific medical missionary societies in Irish universities. The doctor's personality, thus operationalised as a facet of medical practice on the missions, was envisaged as a foundation stone of RCM medical independence. This independence would be further bolstered by the unique symbiosis imagined between the lay male doctor and the Sister doctor

> summed up by saying that the reliable permanent staff will be supplied by the Sister doctors and that the free lance volunteers supply that male strengthening element which is so beneficial especially in surgery. Such a combination in one hospital would allow that division and specialisation of labour which is so necessary in modern medicine.[14]

The contrasting roles of men and women, of doctors, priests and Sisters, became a recurrent theme in the management and development of the RCM Ogoja leprosy scheme, raised again and again with reference to issues of recruitment, institutional stability, and endurance as the coverage of the leprosy scheme grew both in numbers treated and in geographic spread. For

[13] Ogoja Convent Files. Report entitled *Mission hospitals and their staff*, undated. The report emphasises the importance of good health, with particular reference to 'the common dangers of tuberculosis to which the Irish are all too prone'.

[14] ibid.

the Medical Missionaries of Mary, a central issue lay in the competing rights of the local bishop and of the MMM Superior General to determine the placing and work of specific Sisters. The corporate contract between the RCM in Ogoja on the one hand, and the Medical Missionaries of Mary in Ireland and Nigeria on the other, derived from the difficult staffing experiences of the first twenty months of MMM work in Ogoja.

The notions dear to Barnes of charity, zeal and generosity in medical work, clearly visible in the report of the Emekuku meeting in 1944, are reasserted in a letter to Martin in 1947. Commenting on the problem of finding and equipping men [sic] to carry on medical missionary work, and on the efforts to stabilise the flow of lay missionary labour to Nigeria by means of organised medical missionary societies, Barnes wrote that

> To my mind there is too much of a bargain touch about [the medical missionary society]. It lacks that spirit of giving and not taking, labouring and not asking reward which is so essential in a spirit of charity. Furthermore there is a certain character with a touch of wildness in him who makes the best doctor, whom I fear will be driven off by the [slightest smell] of institutionalism.[15]

At the same time as this wild character injects his dynamism into the development of medical enterprise, the Sisters who assist in the implementation of the scheme present the assiduous and caring face of healing:

> It is in [the] quiet spirit of laborious prevention, non-dramatic cures, painstaking accurately controlled scientific investigation that the Medical Missionaries of Mary must take up Leprosy. Their charity must be all-embracing including not only the unfortunate heartrending advanced case, but also the child with a tiny patch and even the protection and defence of the whole community.[16]

Commenting further on the gendering of medical work, following discussion with Martin, Barnes wrote:

> surely a hospital run only by a woman, no matter how excellent in themselves and proficient in their work, would be a lob-sided affair without the decision and push that a man can give to it.[17]

Minutes of meetings of the European staff of the Ogoja leprosy scheme dating from the

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[15] MMM archives - 1/Fou/4(n)/4. Part of letter from Barnes to Martin, dated 1947. The date attributed to this letter is taken from the relevant guardbook in the MMM archives, Drogheda. The use of almost identical phrases in notes compiled by Martin in late 1946 and early 1947 on proposed plans for Ogoja Province suggest that the dating can be refined to 'early 1947'.

[16] J. Barnes, 'The outlook for the leper of the future', in *The First Decade: Ten Years' Work of the Medical Missionaries of Mary 1937-1947*, (Dublin, 1948), p. 57.

[17] MMM archives - 1/Fou/4(n)/3. Notes for future reference compiled by Mother Mary Martin after discussion with Mgr. McGettrick, the MMM Sisters, Ogoja, and Dr. J. Barnes, during her Visitation to Ogoja Province, late 1946 and early 1947. The quotation is taken from an addendum at the end of the notes.

second half of 1947[18] yield some insight into the translation of ideological concerns into issues of relevance to day-to-day operations and concerns, arising from specific events and problems occurring across the field of operation of the scheme. From the hurriedness with which some of the meetings were conducted, an oblique sense emerges of the busy working lives of those co-ordinating leprosy control over the great area involved.[19]

As the segregation villages supervised from Ogoja grew in size, the complexity of the task of supervision similarly increased. The first meeting between Dr. Barnes and Sisters Aloysius, Imelda and Brendan of the MMM convent, Ogoja dealt with the question of married quarters, the healthy children of leprosy patients, the provision of a rest house for the doctor, staff training and the roles to be taken up by Sisters. Much of the impetus behind decision making, or at least the arbitration in this regard, seems to have come from Barnes. Thus, regarding the issue of married quarters, Barnes' feeling that it was not necessary at present was noted, commenting that married quarters 'detracted from the naturalness of the villages', though they would 'lessen sex palaver', concluding with the principle that each zone, be it male, female, or married, 'should be linked up and run into the centre'.[20]

This concern with the ideal spatial arrangement of the village was further evidenced by Barnes' recommendation for the treatment of early cases in a separate part of the compound, and the insistence that healthy children be separated from parents being treated for leprosy, Barnes being of the opinion that such children 'be left at home and visited regularly'.[21] When it came to division of labours among the European staff, it was decided that as well as a Sister-Nurse, responsible for the training of African nursing and attending staff, there would be a Sister-Almoner, with 'knowledge of photography, bee-keeping, farming, craftsmanship

[18] The minutes of Ogoja Leprosy Scheme meetings for the second half of 1947 and the first half of 1948 were found in a folder at the MMM Convent Files in Ogoja. It is unlikely that even these minutes constitute a full record of the meetings held between 31st May, 1947 and 15th May, 1948 (the dates of the first and last meetings for which minutes were found), as the time between meetings varied from one week to one month, with long runs of weekly meetings. The first meeting for which minutes exist is headed '1st Meeting by Dr. Barnes in Sisters' house, Ogoja'.

[19] The minutes for the meeting held on 18th August, 1947 begins 'The Minutes of the previous meeting were not read as the Doctor had very little time at his disposal, and it was decided only matters of very great importance would be discussed at this meeting.'

[20] Ogoja Convent Files. Minutes of meeting at Sisters' house, Ogoja, 31st May, 1947.

[21] ibid. Whether the visiting was to be by the parents or the staff of the leprosy service, is not indicated by context.

and architecture',[22] and a Sister-Secretary, responsible for book-keeping, draughtsmanship and administration. In theory, each Sister would be put at the job they liked best.

By mid-1947, it was felt that the leprosy scheme had got off to a good start, a notion evidenced by the instituting of a new injection regimen.[23] Whereas patients had originally been injected every day in order to keep them in the village, it was decided at this stage to inject either 5 cc or 2 cc once or twice a week, depending on the severity of the patient's condition (since the injected treatment, chaulmoogra oil, was held to be most effective with early cases,[24] the smaller doses were administered to those referred to as Stage 3 cases, in whom the disease was most advanced). The second meeting gave instructions on the methods of injection, whether intradermal or sub-cutaneous, to be used when treating each stage.

This meeting also set out the responsibilities of each of the MMM Sisters - Sr. Aloysius was to take charge of bush stations, pharmacy and theatre, Sr. Imelda in charge of wards, complaints, injections, dispensary, and occupational therapy of Stage 3 patients. The understanding of occupational therapy, especially with regard to the most extreme cases, takes on a spiritual and expressly Catholic inflection at this stage of the implementation of the leprosy scheme. The minutes record that

> the occupation [sic] Therapy of Stage 3... will take the form of some manual work or something to occupy their minds. For example: Religious Instruction, prayers, Life of Our Lord. Dr. Barnes says there must be some form of occupation for them as they are very neglected. There will be no blessing on our work until we do something for them. The Doctor is keen on an Horarium, as the treatment for their minds is as essential as treatment for their bodies. It will be experimental in the early stages.[25]

Sr. Brendan would be in charge of the:

> secretarial department, compound patients (clean) the prisoners (lepers), buildings (private & public), admissions, school & technical, Legion [of Mary] & choir and church, gardens, trees, arts & crafts,

[22] ibid.

[23] The relation of this new regimen to the recommendations contained in Money's report are not mentioned - indeed, the issue of discipline through injection is mentioned almost casually, and then held to have been superseded by an internally generated revision to injection practices.

[24] J. Barnes, 'The outlook for the leper of the future', p. 54, writes 'Injection of Chaulmoogra... [is] not a radical cure for Leprosy... the majority of early cases do clear up and do not relapse. The same however cannot be said for the advanced cases especially for the virulent form known as the lepromatous type in which the Bacilli abound.' This article is reprinted at http://www.medical-missionaries.com/healing/hansens/j-b-47.htm

[25] Ogoja Convent Files. Minutes of meeting of European staff, Ogoja L.S., 7th June, 1947.

bees, industries.[26]

We see here how the development of the village necessitated a fairly well regulated and defined separation of responsibilities. The operational significance of this division manifested itself almost immediately, following an examination of school children in the village. Barnes found that 40% had enlarged livers, mostly attributable to a 'methyonane'[27] deficiency. The meeting records that

> To overcome this deficiency the people must be encouraged to eat more and more eggs and this calls for the pushing on of the poultry farm. We must grow crops for the fowl. Needless to say this is a Social rather than a Medical matter and should be treated as of first class importance by the Sister Almoner. The Doctor points out the deficiency and the Sister Almoner rectifies it.[28]

While the idea of a craft-industrial and agricultural complex on the scale of Itu had never been envisioned for Ogoja, the ambitions of self-sufficiency and self-reliance were very much to the forefront in the philosophy of the Ogoja Leprosy Scheme. Thus, Barnes greeted a letter from the Resident, Ogoja Province on the raising of Nigerian standards of living with the proposal, aired at the meeting, that welfare projects begin among those with the lowest standards of living, by providing model farms for groups of leprosy patients. At the same time the meeting agreed that

> treatment should be given free to the poor and charge its weight in gold to the rich as the Jesuits did with the Quinine powder in the middle of the 17th century.[29]

The religious aspect which often accompanied the activities designated 'social' was also evident in the pastoral side of village life. It was resolved that leprosy village teachers should also act as catechists, so that there would be no need for separate catechists, and also in a 'heartily passed'[30] resolution, that discharges of patients should take place on Christmas Day and on July 2nd, the Feast Day of the Visitation, with a solemn ceremony comprising Mass of Thanksgiving and perhaps the Te Deum. A new announcement on the timing of injections was to be made after Mass on Sunday.

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26 ibid. The confutation of 'prisoners' with 'lepers' is intriguing, and suggests a blurring of categories with regard to how European staff say their roles in the broader public health and administrative sphere. In the typed version of the minutes, the responsibilities quoted for Sr. Brendan are ringed in pen or pencil, with the handwritten comment 'It looks well on paper - but'.

27 probably methionine, an essential amino acid.

28 Ogoja Convent Files. Minutes of meeting of European staff, Ogoja L.S., 28th June, 1947.

29 ibid.

30 ibid.

As the meetings became more established, the range of topics coming under their purview became broader by the week. The meeting of 5th July, 1947 mentioned an alternative local therapy referred to as the 'Bark' treatment for leprosy being tried out on one boy with lepromatous leprosy. As he seemed to be improving, Sr. Imelda was asked to look out for the leaf and seeds of the tree from which the bark came. This treatment was also referred to some months later, when it was reported that no marked improvement was being seen. However, the principle that 'the Bark treatment should be given as fair a trial as Chaulmoogra'[31] was noted. Throughout this time, the central settlement at Ogoja was unable to rely on a constant supply of chaulmoogra oil, and was required to tinker with doses and administer on the basis of greatest need for much of the time. The procedure for this was also worked out at meetings as the problem arose,[32] with Barnes' relying on the administrative efficiency and judicious application to the ideals of charity which he idealised as the particular qualities of the religious sister.

A convent in the context of mission

Martin's visit to Ogoja in late 1946 and early 1947, as part of her formal visitation to MMM sites in Nigeria, was crucial in determining the attitude of the Medical Missionaries of Mary to the variety of enterprises linked to leprosy control in Ogoja. Her notes on discussions with Barnes, McGettrick and the MMM Sisters in Ogoja were compiled under the heading 'Proposed plan for Ogoja'. These notes reflect a specific vision for medical work which the Medical Missionaries of Mary wished to see implemented, and demonstrate a focus on a broader range of issues than leprosy control alone. The layout of the ideal medical unit was to comprise a skin clinic, addressing the needs of paying non-leprosy patients close to the site in which most of the medical work of the leprosy scheme was carried out.[33]

[31] Ogoja Convent Files. Minutes of meeting of European staff, Ogoja L.S., 27th September, 1947.
[32] Ogoja Convent Files. Minutes of meetings of European staff, Ogoja L.S., 5th July and 24th August, 1947 give the fullest account of the ongoing assessment of the situation regarding oil supply and the injection regime.
[33] This institutional formation was to excite much controversy – see Chapter Five for a discussion of trouble at Emanduk, near Ogoja town, in late 1948.

The necessity of developing maternity work was also emphasised for the first time, having long been at the core both of MMM practice and of calls for Catholic religious Sisters to be allowed to practice medicine in the years prior to the bestowal of Vatican permission in 1936. Crèche facilities, sick children's wards, mortuaries, nurses' quarters, and provision for the expansion of facilities were also figured into this well worked-out model of institutional organisation evolved over the previous decade by the Medical Missionaries of Mary.

The planning apparatus for RCM medical work in Ogoja was strengthened yet further by the drafting of a five year agreement between Martin and McGettrick on the responsibilities of the RCM in Ogoja and of the MMMs.[34] The provision of all staff for RCM medical work in Ogoja, including leprosy control and the administration of hospitals, maternity and social centres, was to be the duty of the MMMs. This would include the hiring of lay doctors from Ireland and elsewhere, and would give the MMMs more administrative leverage in the future direction of medical enterprises. Sisters' maintenance would be paid by the RCM and from profits (pointed reference being made to the absence of government grants for this purpose, in contrast to the provision made for European staff at Oji River and Uzuakoli), and the MMMs would pay for outfits and travelling expenses to Nigeria, the RCM Ogoja paying for return from Nigeria.

The cost of medicine for leprosy work was to be strictly contained within the amounts granted by BELRA and Government, and regular accounts would be kept and submitted periodically to the diocese, the leprosy doctor, the MMM Superior General, and annually as sacred returns for submission to the Vatican. Notice was to be given to McGettrick of the removal of Sisters in responsible positions, with time given for McGettrick to make a representation regarding such removals. The agreement reflected both the desire of McGettrick to put the RCM in Ogoja on a more secure organisational footing, and the will of Martin to impose a greater deal of MMM control over the conditions of their missionary and medical work. The tension between these two ambitions were highlighted within months of

[34] MMM archives - 1/Dio/8/33-33a. Two draft copies of a document entitled *Agreement between the Prefect Apostolic of Ogoja Province and the Mother General of the Medical Missionaries of Mary*. The second draft is dated 24th February 1947 and is signed by both McGettrick and Martin.

framing the agreement, when Martin moved a Sister from Ogoja Province to Anua for the purposes of recuperation, informing the MMMs in Anua and in Ogoja but failing to consult with McGettrick. McGettrick's resentment of the violation this entailed is made clear in a letter to Martin where he speaks of the 'injury [to] the tender skin of confidence' and the breaking of 'both your word and your agreement to me', adding that 'if there is one thing in this world I abhor it is a system of uncertainty, change and shuffling that is characteristic of the Catholic Missions here.'[35]

Martin responded with pleas of debility and illness among her Sisters, and flattery regarding the progress of leprosy work in Ogoja, noting that the founding of the Medical Missionaries of Mary had been slow and difficult and was only now beginning to stabilise, even as its commitments seemed to be multiplying.[36] McGettrick, for his part, noted that the building of confidence in Sisters at particular posts was vital, and that temporary and 'loan' appointments were unsuitable, both with regard to the wishes and needs of patients and the relationships between the small numbers of mission staff in Ogoja.[37]

As well as the technical issues broached and negotiated during and after Martin's visits to Ogoja, concern for the spiritual wellbeing of MMMs was continually in evidence in the correspondence between Ireland and Nigeria. Though the first draft of the agreement between Martin and McGettrick in 1947 outlined the duties of the RCM in Ogoja in respect of the religious formation and welfare of the Sisters, concerning Mass, Eucharist, Confession, conferences on religious life and annual retreats, the administration of religious duties for MMM Sisters often devolved onto the Sisters themselves,[38] with continual encouragement and advice from Martin.[39]

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[35] MMM archives - 1/MMM/1/5(c). Letter from McGettrick to Martin dated 18th April 1947.

[36] MMM archives - 1/MMM/1/5(e). Letter from Martin to McGettrick dated 11th May 1947.

[37] MMM archives - 1/Dio/8/40. Letter from McGettrick to Martin dated 8th June 1947.

[38] MMM archives - 1/Fou/4(n)/9. Telegram from Martin to Sr. de Lourdes Gogan, dated 27th August 1947, delegating Sr. M. Brendan to receive the vows of five MMM Sisters in Ogoja.

[39] MMM archives - 1/Fou/4(n.1)/6. Circulation letter from Martin to MMM Sisters in Ogoja dated 15th December 1947. This letter details the development of the congregation, with news of individual Sisters, as well as offering advice to the Sisters on the development of their own medical work in Ogoja, and offering and seeking prayers for the work of the congregation across its mission field.

The contrast between the duty of implementation with which the MMMs were charged by Barnes, and the independent development of a strategic vision, as expected by Martin, animated the dynamics of gender relations on the mission throughout its early years. Elizabeth Barnes, who came to Ogoja as a doctor to join her husband Joe between 1948 and 1951, later recalled that 'the administration of.. the villages was very good... it worked very well, considering the whole thing was done on a shoestring.',[40] giving much of the credit to the bustling and unobtrusive efficiency of the MMMs. However, Martin's robust intervention at this stage presaged a growing confidence among MMMs which would bring them very much centre-stage in developing leprosy control in Ogoja Province over the following decades.

Emerging from behind the scenes: the making of Visitation

> The central theme of the film was to show... the work of the Medical Missionaries of Mary in the field and also to link it up to the work of training in Drogheda.[41]

Vital in the elaboration of theories of Catholic leprosy control, and of crucial importance in infusing day-to-day events in Ogoja with a sense of the spiritual and the momentous, was the feature-length documentary *Visitation: the Story of the Medical Missionaries of Mary.* This film would propel the MMMs to renown in Catholic circles in the UK and the US, and underpinned much of the congregation's later independence and fund-raising abilities.[42] The film presents an abstracted and idealised portrait of the missionary encounter with Africa and Africans, at the same time managing to epitomise the variety of pressures framing the potential of the RCM's endeavours in Ogoja, while demonstrating the mission's perception of and rhetorical stance on these pressures. Even more so, it represents a high-water mark in the aesthetic politics of mission, consciously constructing a poetics of this particular form of imperial endeavour.

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40 From author's interview with Drs. Joe and Betty Barnes, 27th Mar 2000.

41 Interview with Sr. Teresa Connolly, MMM, recorded for the 1999 VHS re-issue of *Visitation: the Film Story of the Medical Missionaries of Mary*, (16mm film, 1948).

42 Interview with Sr. Teresa Connolly.

Its role in mediating the Irish, European and North American perception of the work of the MMMs in Africa, and its special focus on MMM work with leprosy in Ogoja among all of the projects in which they were engaged, underline both the significance of leprosy control in the formation of MMM missionary identity, and the importance of interpreting and explicating the particularly complex medical labours attendant on leprosy control to their potential donor constituency. The minutiae of its 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 and codified as patient, builder, inmate, neighbour and Christian, enables the theorising of a Catholic mission rhetorical stance on the pressures framing the evolution of the leprosy scheme, and facilitates the insertion of Catholic discourse on leprosy control into a broader set of notions and practices surrounding the disease in its Nigerian and colonial setting.

Film and cinema were evidently an important signifier of identity for such a self-consciously novel missionary enterprise as the Medical Missionaries of Mary, and reflected an increasingly acute awareness among Catholics of the propaganda value of film. This had been signalled in the papal encyclical of Pius XI, *Vigilanti Cura (On Motion Pictures)*,[43] which exhorted Catholics interested in the propaganda use of film to employ only the best methods and technicians. Martin's search for an appropriate team to help channel and realise her vision were to take her to London, and to a noted producer of wartime documentaries and religious films, Andrew Buchanan.

The efforts involved in producing the film *Visitation* are given a treatment as epic and singular, in a book by Buchanan on the making of the film, as that given in the film itself to the labours of the MMMs and the procedures involved in leprosy control. The means by which cinematic artifice model and represent reality are carefully explicated by Buchanan in a revealing and often startling essay, documenting a series of meetings with Mother Mary Martin, the difficulties in evolving a scenario for the shooting of the film in its Nigerian locations, and the practicalities of creating, framing, editing and combining scenes in order to

[43] Pope Pius XI, *Vigilanti Cura (On Motion Pictures)*, promulgated 29 June 1936.

generate the final cinematic product.

Buchanan traces the genesis of the *Visitation* project to a London wartime meeting with a Catholic priest working in the North of England, when he was first alerted to the wishes of the MMMs regarding film production for training and illustrative purposes. Tying in with nascent efforts to form a Christian group to develop religious film production, of which Buchanan was a part,[44] his interest was piqued, and a correspondence with Martin followed. At their first meeting, Buchanan took pains to outline the intricacies of the production process to Martin, raising questions of distribution, format and documentary technique. Though Buchanan was keen to illustrate the centrality of religion to conceptions of how life should be lived in 'this world of wars and weariness, shortages, queues, political tyranny, militarism, and all the rest of it',[45] he professed himself wary of the acceptability, even to Christian audiences, of 'a truly Catholic film'.[46]

For Buchanan, then, the hurdles to be negotiated even before filming began were how to distinguish 'Truth' from 'propaganda', and reconcile this distinction within a documentary format, and how to develop a film treatment which would suggest outlines for filming and production in advance of any clear ideas on what should be included in the film. Martin, taking up a theme which is consistently rehearsed in studies and hagiographies of Irish Catholic mission, originally wished to situate the development of the Medical Missionaries of Mary in the broader history of Irish missions, and suggested a prologue ranging from the sixth and seventh centuries, to the Danish, Norman and English invasions which forced an interregnum characterised as 'seven hundred years of persecution', followed by the 'rebirth'[47] of the Irish missionary tradition in the early twentieth century. This had formed the kernel of a previous proposal to an Irish production company, but was deemed unsuitable by Buchanan on the grounds of cost and the necessarily fictive tendencies of historical reproduction on screen.

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44 A. Buchanan, *Visitation: the Film Story of the Medical Missionaries of Mary*, (Drogheda, 1948), p. 16.
45 ibid., p. 24.
46 ibid., p. 22.
47 ibid., pp. 28-29.

The negotiations on this pre-planning stage of the production were suddenly brought to a head by the news that Martin would be departing for Nigeria at short notice on the formal visitation[48] to MMM foundations abroad, and hoped to make the film during her visit. This crystallised the notions Buchanan had presented to Martin regarding the use of commentary to build up context, and the need to focus on strong visual representations of the work carried out by MMMs. Charged with assembling a production crew at short notice and despatching portable equipment with them to Nigeria, and faced with long delays in arranging sea passages and the high cost of freighting equipment and crew by air, Buchanan rented a utility truck and sent personnel, cameras, film stock and provisions overland via Tangier, the Sahara and Kano. The film crew met with Martin in Ogoja in early 1947, arriving some two weeks into the second visit of her visitation entourage to Ogoja.

Buchanan was somewhat surprised, and admitted to bewilderment,[49] when the first 8,000 of the 20,000 feet of film stock mooted for the Nigerian section of the shoot, freighted to London while filming continued in Nigeria in order to ensure the viability of the stock and the correctness of the techniques applied, was devoted almost entirely to leprosy. He reported that the photographic quality was excellent, but wondered why the lengthy and in-depth coverage of one particular set of medical practices, especially in the light of imagined shapes for the final film. After a series of cables, and with the eventual arrival of airmailed explanations, Buchanan understood that:

> The result of numerous discussions with religious and medical authorities in Ogoja, together with the intensely interesting nature of the work, had led them to expend the extra footage on leprosy in the belief that a separate film could be made of the subject, using any surplus material for inclusion in a second film to cover all activities.[50]

Examining the shoot itself, it is clear that the aesthetic illusion perpetrated in *Visitation* has a material substrate which is emphasised in Buchanan's account of the Nigerian filming. The use of light portable cameras, with no apparatus for sound recording, freed the production

48 This visitation lent one sense to the eventual title of the film, the notion of missionary and medical work itself as a form of visitation being another, while the representation of Our Lady's visitation to her mother before the birth of Christ which formed the opening and closing sequences of the film unifies the senses of the term suggested by the title.

49 Buchanan, *Visitation*, (1948), p. 45.

50 ibid., pp. 46-47.

team to adopt whatever angles they felt were suitable. Though lightweight lamp-holders and stands were taken to illuminate dark interiors, these were never used due to the absence of electrical current. As a result, interior lighting was achieved using reflector boards covered in silver foil, manipulated to direct sunlight under the eaves of the leprosy hospital buildings, which were fortunately almost universally built with low walls, pillars and thatched or zinc roofs. Buchanan notes the combination of technique, experience, artistry and patience taken to capture the 'polished ebony' gleam of black skin in John Page's 'exceptionally beautiful studies.'[51] Indeed, at one point in the filming, Page went so far as to have the roof taken off a church to film a ceremony within.[52]

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.[53]

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.[54]

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

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51 Buchanan, *Visitation*, (1948), pp. 42-43.
52 ibid., p. 44.
53 ibid., p. 43.
54 ibid., p. 43-44.

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.

The problematic evolution of the RCM Ogoja leprosy scheme and the intensely negotiated and contested engagement of the missionaries with the realities of life in colonial Ogoja were collapsed into an idealised abstraction by the filming and presentation of *Visitation*. The manner in which this happened, and the way in which the film was used to reposition MMM medical practice as scientific and progressive, signified a transforming moment in the history of the scheme. Compressing a variety of themes impinging on the conduct of leprosy control, the film performed the intellectual and ideological labours necessary to underpin the financing and consolidation of the scheme. It also did much to elaborate an ethos which was in the course of construction of the previous years, and helped wrest the initiative with regard to the shaping of this ethos from the originators of the leprosy service, to those Medical Missionaries of Mary who would ensure its continuity over the next twenty years.

The close construction and careful mise-en-scène of the film, resulting in the iteration and distribution throughout its course of linked tropes of voyage, of medical technique, and of the pleasures of receiving medical charity, are therefore pivotal in weaving the Medical Missionaries of Mary into the very fabric of the RCM Ogoja leprosy scheme. In this respect, the identity emerging between the body of missionaries and the medical enterprises attending the leprosy scheme effectively overshadows the generation of foundation myths relevant to the RCM Ogoja Leprosy Scheme itself, subsuming the story of Ogoja into a broader story of Medical Missionaries of Mary charity and growth.

Thus, as the celebration of the Mass by the Archbishop of Armagh at the MMM Convent in Drogheda transmutes, in the opening scene of Visitation, into a similar celebration by Bishop Moynagh in Calabar Diocese, the viewer is introduced to the 'historic trek'[55] of Marie Martin

[55] Buchanan, *Visitation*, (1948), p. 79.

into the Calabar hinterland in 1921. With Sr. Philomena Doyle from RCM Ogoja making 'a perfect 1921 Miss Martin'[56] according to some of Martin's early spiritual companions, the reconstruction of this voyage is presented as a descent into jungle and journey upriver by canoe, where 'Martin' is accompanied by two African women. The 'arduous, momentous journey' is shadowed by a 'frightening silence', the exhausting monotony broken only by a 'cool stream' and 'water as smooth as glass'.[57]

The hostile jungle and benign waters take Martin and her companions 'further from all traces of civilisation' to 'scattered African villages [whose] primitive, clustered dwellings move past [the canoe] like pictures in a dream'.[58] The description of this vignette in Buchanan's text reiterates the givenness of the primitive nature of the Nigerian interior, from dwellings, to 'people who probably have never seen a white-skinned woman, judging by their primitive conditions', to the endless mass of humanity arrayed for the panning camera as a 'primitive pageant' of overcrowding, misery and disease.[59] This, the viewer is told, is the Africa she found, where chief among the signalled medical concerns were maternity care and leprosy.

The narrative takes the viewer through the founding of the MMMs, and a number of their hospitals and medical systems in Nigeria, depicting maternity visits, orphanages, dispensary clinics, and intersecting with the 1946-47 visitation of Mother Mary Martin for the first time in Afikpo, Ogoja Province, where a hospital is being 'built and staffed by the Medical Missionaries', in conformity with government regulations.[60] The journey from 'the flat country of Calabar to the hilly area of Ogoja Province', bringing out the contrast between the two areas in which the MMMs worked, paves the way for the section on leprosy, which takes up the bulk of the film's running-time.[61]

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56 MMM archives - 1/MMM/1/5(a). Letter from Martin at Anua, Nigeria to McGettrick dated 11th April 1947.

57 Buchanan, *Visitation*, (1948), pp. 78-79.

58 ibid.

59 Buchanan, *Visitation*, (1948), pp. 79-80.

60 Buchanan, *Visitation*, (1948), pp. 94-96. The conformity with government regulations is stressed, though this sense of modernity is leavened with a description of the absence of machinery on site, and a likening of the building of the hospital to the construction of the pyramids in Egypt, the implication being that 'untold difficulties [are] being surmounted by the power of pure Faith'. Intriguingly, while Buchanan's text mentions the role of the priest as supervisor on the building site, the role of the lay doctor in the running of the hospital is not mentioned, though he is seen in the film.

61 Taking timings from the 1999 reissue of *Visitation*, the leprosy section accounts for thirty-eight minutes of the fifty-seven minute running time, the diagnostic journey of Akong which forms the centrepiece of the

The thematic complexity of the leprosy section of the film matches the institutional complexity of the RCM Ogoja leprosy scheme itself, and attempts to re-map the parameters of its operation according to Catholic mission conceptions of leprosy and leprosy sufferers, of charity, and of spiritual and social work. Consequently, the viewer's first glimpse of the scheme is at the furthest reaches of its sphere of operation, 'a shady corner of an outlying village [where] a Sister is sitting at a little table, and standing around her are a number of villagers awaiting inspection'.[62] On seeing a villager with no marks of leprosy infection being dismissed, a voiceover informs the viewer that there are an estimated 37,000 leprosy sufferers in Ogoja Province, representing 5% of the population, with children and young adults seen as most susceptible to the disease.

The presentation introduces a man given the name of Akong, of strong and healthy appearance, who presents himself to the Sister 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,[63] his diagnostic journey is set in train. His journey to the Village, 'with his few belongings balanced on his head',[64] 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.

presentation taking up just over ten minutes of this time.

62 Buchanan, *Visitation*, (1948), p. 97.

63 As in many of the earlier (and some later) texts produced by the RCM in Ogoja, the word 'leper' is used throughout to designate the leprosy sufferer and patient. The medical currency of this term, identifying the person of the sufferer with the disease, ended only with the Havana International Leprosy Congress of 1948, though popular usage continued in Africa and in Europe.

64 Buchanan, *Visitation*, (1948), p. 98. This is one among many scenes which explicitly contrast daily life and routine practices in African and European contexts, with the subtext that the medium represented by the leprosy settlements' 'African Village' life constitutes an ideal hybrid of the familiar and the revolutionary.

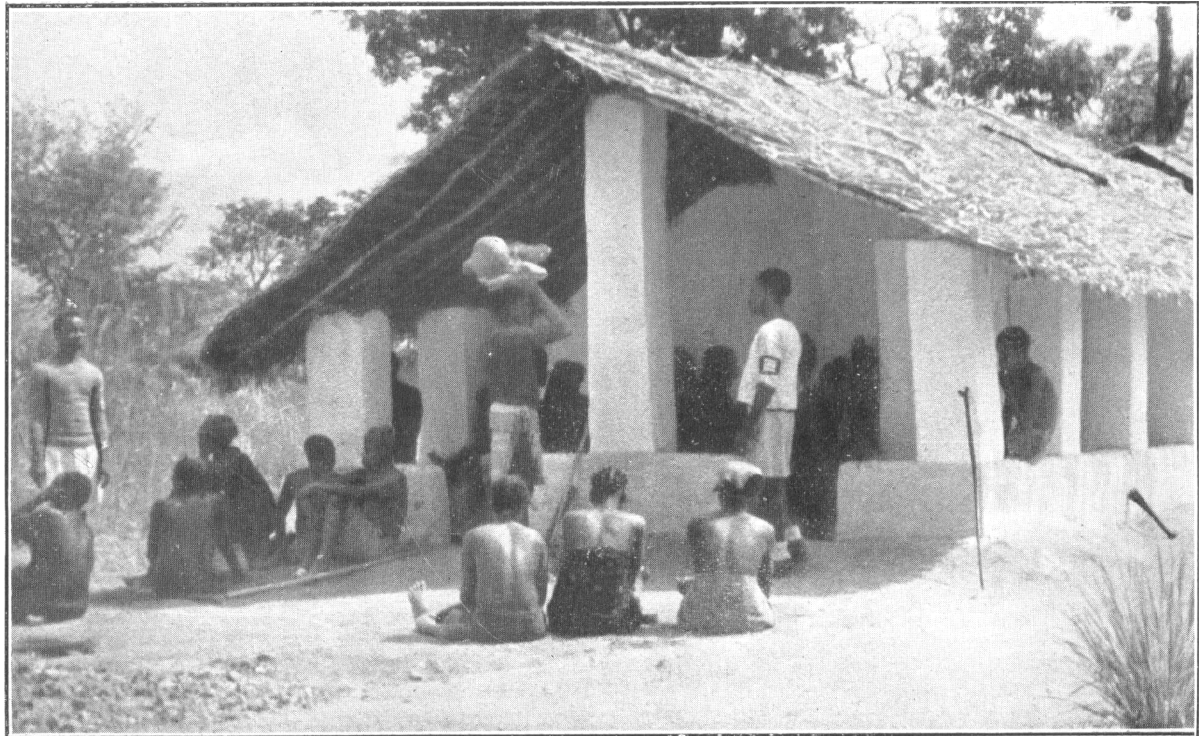


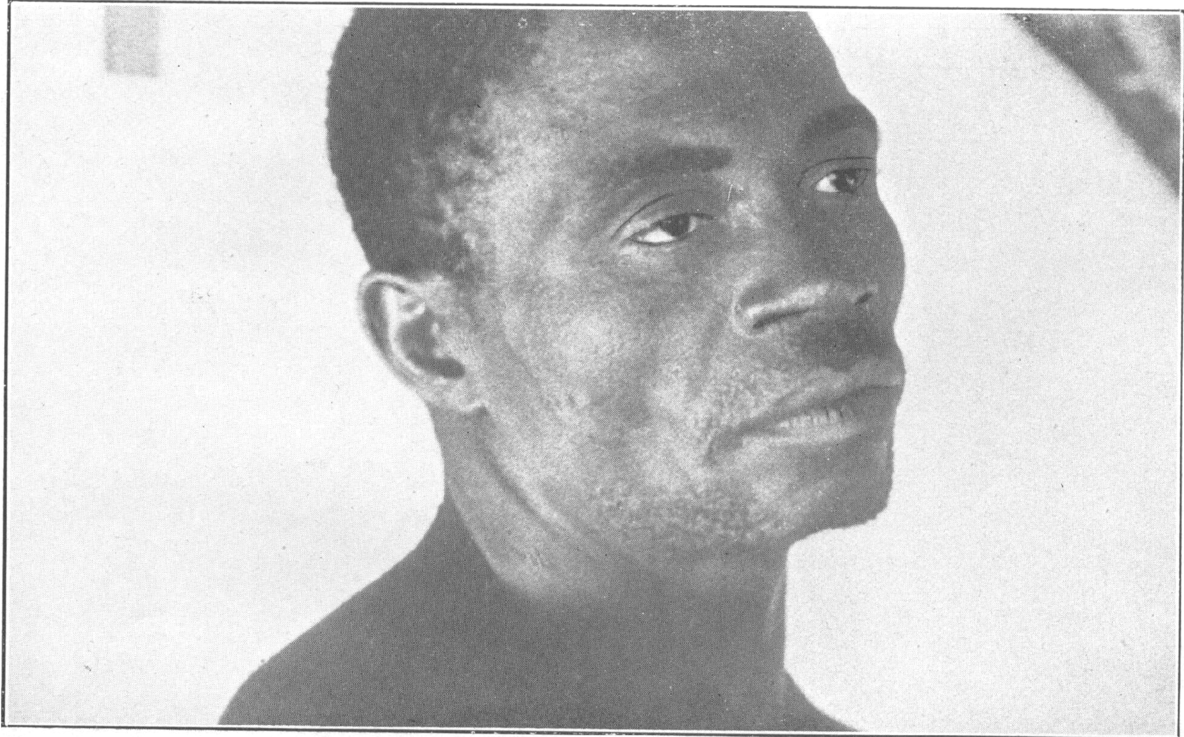
Figure 3: Film still – Akong's arrival in Ogoja[65]

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 an ulcerated limbs, and another with a goitre, noting that leprosy makes of its victims 'a race apart'.[66] 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.'[67]

As his diagnostic journey is narrated, Akong is prodded, painted, dusted, and pinched; the doctor, conducting visual, touch sensitivity, and hot and cold tests, examining nerves and

[65] Buchanan, *Visitation*, (1948), between pp. 74-75.
[66] Buchanan, *Visitation*, (1948), p. 103. This phrase, along with much of the second half of Buchanan's text, is also used in the narration of the film.
[67] Buchanan, *Visitation*, (1948), p. 102. The unglamorous capture of 'Truth' by the documentary filmmaker is contrasted positively with the fictive entertainment pursued in 'extravagantly produced' feature films, the dramatic intensity in the former emerging in measure with correspondence to 'reality'.

swellings, and relating judgements to a clerk who maps the findings onto a chart corresponding to the front and rear of the patient's body, suspects Akong to be 'neural type - stage two' and sends him to the adjoining laboratory for further tests. Focusing on the body on which the tests are administered, the chart on which the details are noted, and the hands of the doctor and the clerk, the notion that Akong is confirming his reactions is communicated by the narration, rather than by focus on his own response, the film thus serving to cathectise the passivity of the leprosy patient before medical practice.



Akong learns he is a leper

Figure 4: Film still – taken from *before* diagnosis[68]

This passivity is underlined in the section describing the laboratory tests. While the visual sequence recounts the conduct of a pilocarpine[69] test to determine whether the skin patches attributed to leprosy characteristically fail to sweat, and a smear is taken from a patch, Akong periodically wincing as the procedures take their course, the viewer is informed of the

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68 Buchanan, *Visitation*, (1948), between pp. 74-75.

69 Buchanan, *Visitation*, (1948), p. 106-07 recounts 'The first operation is to inject pilocarpine into the skin, which will produce sweating if the area is normal. Leprotic patches do *not* sweat. Akong winces as the needle pierces his skin, but he is very brave and obedient. The Sister then paints the injected parts with iodine, and sprinkles dry starch over them, which will remain white and dry on infected patches, but will turn dark blue on normal healthy skin.' (italics in text)

diagnostic classes of leprosy, and the root of the germ theory of leprosy in Hansen's discovery of the bacillus in Norway. The process of seeing patients is subsequently summed and abstracted in the retreat of the doctor and Sister to the 'research section of the laboratory' to examine the day's slides. In this crucible, the result of the barrage of tests waged on the body of the patient is confirmed by the revelation of 'definite leprosy bacillus' on Akong's smear test, and as the microscopic view of the smear is presented to view, it is intoned that 'Akong is a leper, and so is admitted to the village'.[70]

While the diagnostic journey is characterised by abstraction and passivity, the admission to the village introduces the patient to an industrious and organised community, reflecting an ideal of African village life, at once exoticised by the routines and institutions pertaining to leprosy control and normalised with reference to the patterns of African life, work and craft. From the point of view of cinematic presentation, the encounter of the patient with the institutions of leprosy control and segregation is characterised by the virtues of faith, community, friendship and solicitude, combating the posited dual isolation of the patient from his home village, and of the segregation village from the broader world.

The notion of faith is constructed in relation to both the medical and the spiritual. In an apposite admission of the ambiguity of medical practice, in the specific instance of the segregation-based approach to leprosy control, the viewer is informed that 'the patients have complete faith in [chaulmoogra oil's] healing powers, which helps to prevent them leaving the village for they cannot be forced to stay'.[71] The medical work, the performance of which is ascribed to the doctor and Sisters, is paralleled by the spiritual and social work carried out by the Fathers. These works merge in the ideal progress of the pagan patient to Baptism, where the cure is notionally completed with the assumption of 'new-found spiritual armour'.[72]

The sense of community fostered in the village is underpinned by supervised schooling and labour, and Church attendance for the Christian patients. The viewer is told that 'life in the

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70 VHS reissue of *Visitation*, 1999.
71 ibid.
72 ibid.

leper village is made as normal and homely as conditions permit',[73] and the school, where children are taught by a patient-teacher, is paraded as revolutionary, bringing the written word, the outside world, and tales of 'man's great achievements' to Ogoja. At the same time, the contrast between rapt attention and recitation, and teasing horseplay among schoolchildren act as markers of normality for the viewer, while the school band is said to introduce a celebratory tone to both routine and special occasions in village life. The impression of well-organised village life is underlined by a focus on work practices, assignments being made at a daily assembly according to physical fitness of the individual, with manual, agricultural and construction tasks being carried out assiduously and competently. The transformation of work into industry, through the offices of supervision and organisation, is presented as a hallmark of the apolitical and idyllic African village life presented by the film.

With evening, the industry of daytime mellows into cool tranquillity, and the friendship and solicitude which constitute the fruits of medical charity are seen to come into their own. As missionaries circulate and joke with patients, and the schoolmaster serenades his wife on the guitar, the members of Legion of Mary in the village help with setting fires and cooking for the disabled, meeting for prayers once a week under the direction of the Sister Almoner. The leavening of the routine with the spiritual and the infusion of the patterns of everyday life with a sense of journey towards healing, knowledge and redemption are persistently re-thematised through the course of the film, as missionaries are seen to interact with and bring succour to the heart of African life.

The self-contained calm of village life in Ogoja is contrasted with the forward-looking dynamic of the RCM Ogoja leprosy scheme as a whole, epitomised in a sequence showing Barnes, McGettrick and Martin consulting a map during Martin's visitation to Ogoja. Their consultations, hinting at a broader strategic vision both in terms of the leprosy scheme, and the mission of the MMMs, frame an examination of the problems of related villages at Abakaliki and Obudu, with as yet insufficient staff, and forming part of the ambitious plans

[73] ibid.

of Barnes and McGettrick. The 'ceaseless effort' and endless call for more medical missionaries working on leprosy control are contextualised by Martin with reference to plans for the hospital in Drogheda and maternity clinics throughout Calabar and Ogoja provinces.

Mother Mary makes known the overwhelming and urgent need for Sisters

Figure 5: Film still – shaping future missionary strategies[74]

Throughout the film, the religious sequences were seen, tellingly, to require specially orchestrated sacred music, as a form of 'very special treatment', with the choir of Westminster Cathedral providing the 'Ave Maria' for the opening and closing sections.[75] The punctuation of the film with sacraments of the Eucharist and Baptism, meetings of the Legion of Mary, and religious Reception and Profession ceremonies, suggesting an overarching spiritual ethos, was counterpointed with a series of voyages, crowd scenes, miseries and redemptions, each portended with variations on its own musical theme.

The result was lauded in Britain, where it had a nationwide run in the Odeon Cinemas, and in

[74] Buchanan, *Visitation*, (1948), between pp. 124-25.
[75] Buchanan, *Visitation*, (1948), pp. 63-64.

Ireland, where it toured extensively, as a great triumph of Catholic film-making. In the words of Cardinal Griffin, Archbishop of Westminster:

> [*Visitation*] is a story of exquisite Christian charity, combined with the latest that medical science can provide. It shows how the precept of the love of our neighbour, by alleviating human misery and affliction, expresses the charity we have to show Almighty God.[76]

It was to be a story which underpinned the continued strengthening of the MMMs as a missionary force in Ireland and further afield over the next generation.

The greatest sacrifice: becoming a "Nigerian" mission

The ideal of sacrifice, repeatedly touted in missionary publications and presentations, and experienced by the individual missionary as a means to personal redemption, found its most poignant and powerful expression in the death of a priest or Sister on the mission field. This fate was to befall two MMM Sisters in the course of the congregation's first decade in Ogoja Province, with the accidental death of Sr. De Sales Duignan in a ferry accident between Afikpo and Abakaliki in 1949, and the death from typhoid of Sr. M. Matthew Carey, working at Abakaliki Leprosy Settlement, in 1953. This connection between sacrifice and mission, underlining also the physical instance of the spiritual relations burgeoning between Ireland and Nigeria, is made explicit in a personal letter from McGettrick to the MMM Bursar in Drogheda:

> I am sure you were all shocked by the sad news re Sister De Sales – RIP. God has been asking us for a sacrifice for some time and indicating that one was due and necessary for this work. Se He finally decided on one who was young, energetic, healthy and one whose faith was fresh and pure from Ireland. She will do a lot for us above. The Medical Missionaries of Mary may now be said to have started work in Nigeria.[77]

Martin's consolatory letter to the Sisters in Ogoja Convent[78] elaborated on a number of these themes. Couched amid news of a successful visit to Rome, where Irish doctors presented a

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[76] 'Scenes at the London Premiere of "Visitation": Studio One Cinema, Oxford Circus, June 1948' presented as part of VHS reissue of *Visitation*, 1999. Address by Bernard Cardinal Griffin, Archbishop of Westminster, at London Premiere of *Visitation*.

[77] MMM Archives, Drogheda. 1/Dio/8/59. Letter from McGettrick to Sr. M.B. Roche, MMM, dated 26th September, 1949.

[78] MMM Archives, Drogheda. 1/Fou/4(n.1)/10. Letter from Martin to 'My dearest Mother and Sisters', dated September 1949.

monstrance[79] to the Pope, and a return via Lisieux, where Martin dedicated the MMMs to St. Therèse, asking for the blessing of the saint's surviving sister, she sought to impress on the Sisters that Sr. De Sales' death was 'God's Holy Will' and a source of privilege to her soul, reminding them that:

> Sister was called by God to her eternal reward at her ripest moment, just after her annual retreat, renewal of vows, confession, Mass and Holy Communion and praying on her journey of love and mercy for the African people.[80]

Outlining among the other consolations of her death that she was in the company of an African nurse, who survived, and to whom the sacrifice of Sr. De Sales would serve as an example, that the blessings of the cross were in this way being visited on Ogoja, and that she was buried in Afikpo, where she had served, Martin enjoined the Sisters to visit and keep her grave. The element of display in presenting a missionary death was underlined:

> You will be able to get a nice little cement curbing & cross with inscription – I would have the surrounding to hold a few sisters, not just the size of one grave – others may have the same privilege, and of course you will have Mass for her Month's Mind.[81]

Her reverent and solemn interment at Afikpo reiterated the exemplary nature of her sacrifice, McGettrick noting that:

> The Medical Missionaries of Mary have now consecrated the soil of Nigeria with the pure body of their first martyr... she was ready to meet Her [sic] spouse and lover.[82]

In an unforeseen irony, secular confirmation of the corporate nature of mission identity - dramatised in the spiritual rhetoric and ritual surrounding Sr. De Sales' death - was offered in legal advice on a possible insurance claim for loss of life based on the mission's motor policy. The solicitor consulted, a Mr. McCormack at Aba, advised that the insurance company could only indemnify the Mission in respect of a compensation claim filed by an injured party in Mission employ, or by dependants thereof. McGettrick mused that the late Sister's parents would most likely not qualify as dependants, and that the mission would not

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79 See glossary.
80 MMM Archives, Drogheda. 1/Fou/4(n.1)/10.
81 ibid. See glossary.
82 MMM Archives, Drogheda. 1/Dio/8/58. Letter from McGettrick to MMM Convent, Drogheda, dated 26th September, 1949. This letter describes the circumstances of the accident, identifying the presence of Dr. Hinds, Fr. O'Sullivan and an African nurse (whom Martin's letter 1/Fou/4(n.1)/10 names as Nurse Jemimah, following Fr. O'Sullivan's account), absolving any party of blame, and conveying prayers for the parents of the deceased.

be in a position to pursue a claim.[83] This episode demonstrates the role of a variety of legal and business interests in encoding notions of mission as employer, group of employees, Church, and community, and the ambiguities resulting therefrom.

While the death of Sr. De Sales did not impinge directly upon the staffing and conduct of leprosy control in Ogoja Province, that of Sr. Matthew Carey in March 1953 had a greater impact. Sr. Matthew had spent almost three years nursing at Ogoja and Abakaliki Leprosy Settlements, and was taken ill at Abakaliki on 28th February with suspected typhoid. After failing to respond to treatment with chloromycetin, she was taken to the Park Lane Nursing Home in Enugu, where Srs. De Lourdes and Immaculata came from Ogoja to assist in looking after her. Having received last rites on the 14th, she died in the prayerful company of McGettrick and the visiting MMM Sisters on 16th March.

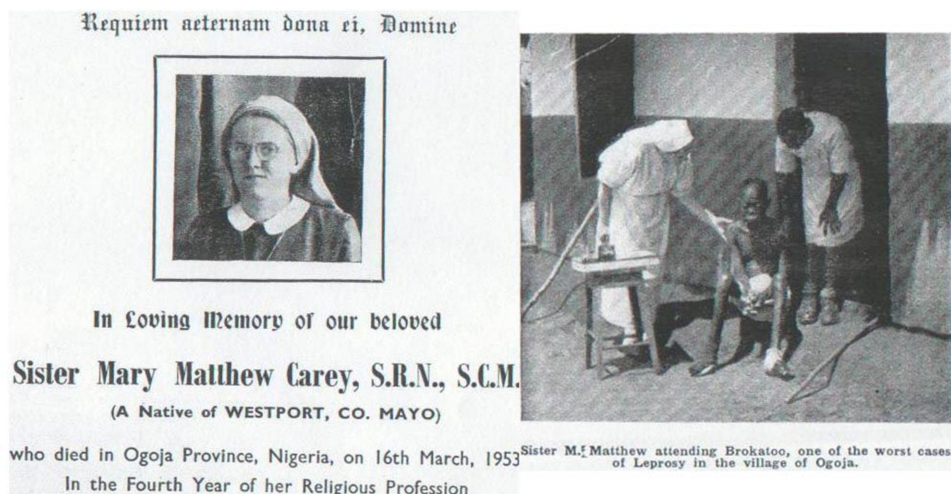

Figure 6: Commemorating Sr. Matthew Carey in *The Medical Missionary of Mary*[84]

In its report of her passing, *The Medical Missionary of Mary* presents the following account, quoted extensively here for its varied thematic resonances:

> She was buried at the Leprosy Settlement, Abakaliki, just beside the Oratory, amid scenes of general mourning. She rests among the lepers whom she loved and for whom she gave her life.

[83] MMM Archives, Drogheda. 1/Dio/8/61. Letter from McGettrick to Martin, dated 4th November, 1949, enclosing copy of letter from Louis Alan McCormack to McGettrick, dated 31st October, 1949.

[84] 'In Loving Memory of Our Beloved Sister Mary Matthew Carey, S.R.N., S.C.M. (a Native of Westport, Co. Mayo): Who Died in Ogoja Province, Nigeria, on 16th March, 1953 in the Fourth Year of Her Religious Profession', in *The Medical Missionary of Mary* 14, 4 (1953), pp. 3-5.

In a touching panegyric, Rt. Rev. Mgr. T. McGettrick... attributed to Sister M. Matthew three qualities of our great Irish Patron and Missionary, St. Patrick: love of prayer, zeal for souls and patience. 'Personally,' he said, 'if asked which Sister was ready for Heaven I would have placed her in the first three... we have to thank God to-day for giving us a martyr. She has given her life for the sick, for the outcast, the fingerless, footless, starved and naked lepers...

The lepers, even the very weak and crippled, come daily to recite loving Rosaries by her grave in gratitude for her loving kindness to them... Their deepening conviction of the power of prayer seems evidence that her work in Heaven of winning Faith for these poor leper souls has already begun.[85]

The notion of the woman religious as an exemplar of faith, devotion and personal ministry is expressly interwoven here with a narrative of the alternately tragic and joyous life-course of the missionary. The tone of suffering, patience and endurance, hallmarks of the religious sister and the leprosy sufferer alike, is rendered all the more crushing by the recognition that leprous bodies contain leprous souls, whose pained poverty can only be redeemed through sacrifice, prayer, intercession, and martyrdom. The figure of the Irish Sister as a metonym for charity and healing is continually honed over the course of MMM reflection on leprosy work in Ogoja, and the quoted passage presents perhaps one of the most intense deployments of this recurrent trope.

Deriving strength of purpose from the reinterpretation as martyrdom of the death of Srs. De Sales and Matthew, the RCM in general, and the Medical Missionaries of Mary in particular, evolved a strong and visceral territorial attachment to Ogoja Province as a mission 'field'. Both fellow Sisters, and families left behind in Ireland were firmly bound to a hallowed corner of Nigeria by means of this self-conscious re-purposing of tragedy as solace and joy. Overlaid on a distinctly gendered roster and rhetoric of duties and fealties within the structure of the RCM leprosy scheme, the startling resonances deriving from Catholic discourse on faith, suffering and death contribute strongly to the creation of a distinct mission identity in Ogoja. Some understanding of this identity is crucial in illuminating the approaches of the RCM to colonial and medical administrators, as well as to the specificities of their medical labours. This sense of identity was fashioned, in the setting of empire, by a group of lay and religious missionaries from the material circumstances of their labour and prayer, from amid the hierarchies according to which they interacted with each other and with Nigerians, from the reports, interventions and creative labours of their broader

[85] ibid.

international Catholic missionary cohort, and from the intimately repellent nature of their work; it mediated both the shortcomings and the resilience of the RCM leprosy control project in colonial Ogoja Province. For the MMMs, the RCM Ogoja Leprosy Scheme constituted a central plank of a very strong, communal sense of identity, communicated in a distinctive tradition of writing about, presenting, and understanding mission and medicine.

Chapter Five - Creating and managing institutional spaces for leprosy control

The systematic creation and management of institutional spaces for leprosy control in Ogoja Province generated a bureaucratic accommodation between government, mission and local communities which differed, both by degree, and absolutely, from any administrative machinery that had been in place earlier in the colonial history of Ogoja. The development of the RCM Ogoja Leprosy Scheme in the decade after 1945 resulted in a set of ordered interventions into the organisation of resources and of political recourse within the hinterland covered by the scheme.

The land-extensive nature of early leprosy settlements and villages gave the missionary Catholic Church an important stake in the delineation and policing of strategic and contested borders between ethnic groups, and in doing so, helped to constitute ethnicity in an absolute relation with concepts of territory and ownership. The discursive labours involved in establishing the competencies and spheres of influence of church, colonial administration, and political actors within local communities are clearly reflected in the record of conflict over taxation, payment, markets, and resource rights, while the uneasy distinction between such fiduciary categories provides a strong index of the nature and course of changes wrought by such a large-scale intervention as a leprosy control scheme.

The political techniques which evolved from the context of leprosy control in Ogoja had a decisive impact on the framing and execution of development, welfare, and infrastructural projects during the colonial period, as well as on the course of medical innovation, in leprosy and more broadly, throughout the province. The refiguring of the leprosy patient as a strategic resource, resulting from a sense of 'clan' ownership of and responsibility for leprosy sufferers among its people, helped to normalise and ground new interpretations of political relations and power structures in the territory at large. The coalescing languages of

entitlement and development[1] gave rise to novel strategies for bargaining, discriminating, and petitioning, amid rapid change in the political economy of late colonial Ogoja.

I begin this chapter by examining the confrontation in practice between the aspirational language of leprosy control elaborated by Barnes in his original proposals for leprosy control in Ogoja and the unexpected everyday problems of negotiating and instituting sites and structures for the leprosy villages as the planned extension of these proposals. This material offers an introduction to how contentious issues regarding land, labour, duty, and taxation were broached and managed in the context of an early extension of colonial development policy in a locality hitherto peripheral to imperial infrastructural concerns.

The rather haphazard methods employed in response to obstacles in implementing the RCM Ogoja Leprosy Scheme rapidly invited official scrutiny by a raft of colonial administrative bodies. Subject to an array of inspections, supervisions, and investigations, the mission was effectively forced to evolve a defensive strategy in order to anchor and safeguard its material and professional investments. This process would enable the mission to formulate policies on Catholic healthcare in the face of increasingly secular and global tendencies in the administration of public health and disease control. Here, I examine the material correlatives of this broader intellectual process, at the level of local politics, thus providing texture to accounts of the relation between mission and ostensibly secular late- and post-colonial development agendas and policies. I show how the RCM Ogoja Leprosy Scheme mediated local expression and reception of global initiatives, how it imbued the rhetoric of development with quasi-spiritual dimensions, and how it helped organise access to strategic resources, creating in the process a Catholic language of entitlement.

[1] Dan Brockington, 'Politics and ethnography of Third World environmentalisms—notes from Tanzania'. African Studies Seminar, University of Oxford, 5th June, 2003, modelled the appropriation of development rhetoric as a means of argument about resource entitlement in the context of land use in southern Tanzania.

Practical issues in missionary leprosy control – i) local

From the outset, the RCM Ogoja leprosy scheme relied for its success on the assent of local groups and the ability to call on the resources of the colonial administration and its extant networks. Barnes' plans for propaganda among the people of Ogoja depended on district officers as intermediaries in suasion and coercion, as well as supports in raising revenue and channelling government and BELRA grants. Having agreed sites, and with five leprosy villages under construction by the end of January 1945,[2] Barnes called on the notably helpful District Officer for Ogoja to persuade local chiefs to send in all leprosy sufferers to the villages where housing was being built. The importance of sending in early cases was especially stressed, as these were seen as more readily curable.[3]

Some idea of how Barnes' scheme was implemented on the ground is given in a series of handwritten and typed notes collated in 1945,[4] which describe the earliest visits made by the leprologist to some of the areas in which it was proposed to set up clinics and segregation villages. The earliest pages consist of a series of notes on visits in the Obudu area as part of an information gathering exercise. Each village entry is broken down into sections on the site of the proposed village, the plan of the village (normally in the form of a hand-drawn map), the design of a standard house in the area, the extent of local co-operation likely, the availability of a suitable local candidate for leprosy nursing, and figures for local population and estimated prevalence of leprosy.

In siting the proposed segregation village, issues such as access to water, separation from concentrations of European and African population, and the local disease ecology were all taken into account. From the brief notes available, it is apparent that the sites to be cleared were generally between 200 yards and half a mile from the nearest road, and around 300

2 MMM archives - 1/Dio/8/16. Letter from McGettrick to Miss J. Powell, Dublin, dated 26th January 1945.
3 Ogoja Convent Files. Copy of letter from the Leprologist, Ogoja Leper Settlement, to the District Officer, Ogoja, dated 29th January 1945.
4 These papers are in the Ogoja Convent Files, and are dated individually at the time of writing. The dates span the period from January 5th to August 27th, 1945. Where handwritten, the handwriting is Barnes' own. The material from April to August 1945 is mostly typed, and consists of reports which may be by either Barnes or one of the three MMM Sisters who arrived in Ogoja at the end of March 1945. This material will subsequently be referred to as Village notes - 1945.

yards from a water source (a stream or a river). The rationale for at least some of the siting decisions is given in an extended note on the site of the proposed village near Ukpe. The Obudu area was known to have a relatively high incidence of trypanosomiasis or sleeping sickness.[5] In the light of this knowledge, Barnes mentions that the proposed site, some 2-300 yds. from the river, 'is theoretically outside the feeding range of the tsetse, which according to Manson-Bahr is 60 yds.'[6] While he concedes that the need to approach the stream for water would expose patients to the tsetse fly in any case, he mentions that the flies are numerous in the area in places up to 400 yds. from the water, and that bush clearing close to streams, traps, and chemical prophylaxis which may be provided by Government should be considered.

Since the environmental interventions (such as site clearing, concentration of population, and on-site medical provision) proposed by Barnes' scheme of leprosy control were to be implemented on a clan basis, and therefore on a local village-by-village basis it would be important that trained staff know how to recognise early treatable symptoms of diseases other than leprosy. In the same note quoted above, Barnes details the early symptoms of trypanosomiasis, and reminds himself to have the Sisters instructed on them and to discover for himself the recommended treatment for the disease.

The standard layout mooted for the villages was referred to variously as 'Celtic cross',[7] 'St. Brigid's Cross',[8] 'the circular plan',[9] and 'the diamond plan'.[10] It consisted of a central square or diamond, with four arms running perpendicularly from this central area. At least some attention was paid to the extent to which this plan would 'harmonise' with the immediate physical surroundings, Barnes writing of the proposed village at Bendi that 'from the top of one of these [surrounding peaks] it should make a very pretty sight lying down below in the valley'.[11] Generally, a local house judged to be well-constructed was taken as a template for

[5] A survey on the incidence of sleeping sickness in Obudu had been carried out by government doctors, and some notes on the incidence of both sleeping sickness and goitre had been sent to Barnes at his own request.
[6] Village notes - 1945. Ukpe, 10th January.
[7] Village notes - 1945. Otukwang, 7th January.
[8] Village notes - 1945. Ukpe, 10th January.
[9] Village notes - 1945. Kakum, 12th January.
[10] Village notes - 1945. Bendi, 14th January.
[11] ibid.

the sort of dwelling to be constructed in the village.

The most revealing material from the earlier notes compiled by Barnes on his village visits comes under the heading of 'Co-operation'. At times it seems that this was as much an intelligence-gathering exercise on the part of RCM-related staff as the intelligence reports of the Nigerian colonial administration some 15 years earlier. Barnes notes whom he should be speaking to and what parties might prove profitable alliances in the effort to mobilise interest, finance and labour for local leprosy control measures. In Obudu, he reports that

> the chiefs failed to turn up in any strength, and only a couple of lepers. Fr. D. says they are a lazy crowd. They too fear the Munchis [Tivi from what is now Benue State] which is the reason they do not want the settlement to the north of the town.[12]

The same note draws attention to tension in the siting of the village, which was to be in nearby Kakum rather than in Obudu itself. Barnes writes that he placated them with the assurance that the leprosy asylum would be in Obudu in two years time. The question of subscription also arises - at this point in time, Barnes did not ask the people of Obudu to subscribe for the construction of a village.

However, a couple of days later in Otukwang he notes that 1s. 2d. per man was promised, totalling £73.15/0, this despite a proclaimed lack of enthusiasm among a population which 'do not appreciate infectivity of disease'.[13] The people of Ukpe promised 2s. per man (which was noted as 'not given') and 'like all the clans in this area they made no palaver about the land',[14] despite the chief being discommoded by not seeing Barnes on his arrival in the village. In Kakum, it was agreed that money already being collected for a general hospital could be 'devoted to the leper village and the remainder to a hospital developed in connection with a leper asylum'. Here Barnes also notes that 'leper settlements are always pestered by clean patients and 'tis necessary to have a clean ward for them'.[15] At Bateriko, Barnes

> was promised everything… but the carriers had to be dragged to work. They have a reputation for laziness which seems well deserved.[16]

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[12] Village notes - 1945. Obudu, 5th January.
[13] Village notes - 1945. Otukwang, 7th January.
[14] Village notes - 1945. Ukpe, 10th January.
[15] Village notes - 1945. Kakum, 12th January.
[16] Village notes - 1945. Bateriko, 17th January.

On a later tour of preliminary visits nearer to Ogoja town, the perceived link between the subscription for the leprosy village and Native Administration taxation was raised by some among the Akaju [sic] clan near Bansara, who 'maintained that as their tax had to be raised to 6s. 6d. per man the N.A. ought to build the houses'.[17] One local group refused to come in as a subclan, despite being too small for a separate village - it was arranged that this group would build a house for any individual leprosy sufferers from among them. At Kackwagum [sic], a smallpox epidemic led to low turnout among the chiefs. Those who did turn out agreed to put the matter to the others.[18] However, Barnes was not impressed by the response of the Nkim Clan. He wrote:

> The people have a poor reputation for work - they hire Munchis to do it for them. The King who is said to have real power would promise you the eye out of his head but wouldn't give you the clippings of his nails. He is an ex-steward... and wily as they make them.[19]

The search at each location for a suitable candidate to nurse at the leprosy village gives some indication of social and educational services already existing in the area as well as of the seeming indiscriminateness of leprosy infection. Although there has been some correlation between infection with leprosy and poverty in the Ogoja area, the high incidence in parts, and the varying level of stigma associated with the disease meant that leprosy patients, from among whom the nurse would be drawn, originated at all levels of local society. A note on the Yakoka Clan at Abuochichi reports, for instance, that the first clinic held there was 'not very satisfactory. Chiefs who are lepers themselves do not want to attend for injections'. Therefore, though one has to be cautious about using evidence on the availability of leprosy nurses suited to Barnes' purposes as an index of penetration of colonial social services, the well documented shortage of such services in Ogoja Province is further indicated by the difficulty in finding literate or trained staff in the early years of the Ogoja Leprosy Scheme.

At Otukwang, Enyom Ebe, a young leprosy patient, was noted as having 'very little English - no book - not so good'. Yet he is the only candidate listed under the heading 'Nurse'. At Ukpe, Utu, son of Addia of Ugbong, had good English but was illiterate. It seems that he

[17] Village notes - 1945. Akaju Clan, 1st March.
[18] Village notes - 1945. Kackwagum, 10th March.
[19] Village notes - 1945. Nkim Clan, 17th March.

may have had some nursing training, and he is referred to as 'excellent material'. At Kakum, there was a trader with a little English and no schooling, and a 'fine young Catholic' who was crippled in both hands. Barnes suggested the latter as potentially an 'excellent catechist'. For some locations, the 'Nurse' section is left blank, and there were very few trained nurses, not many literate candidates, and some areas for which no-one could be found with the requisite English to communicate both locally and with the doctor.

The notes made between April and August 1945 consist of supervisory reports on work in progress at sites where the construction of a leprosy village had already been agreed and arranged. The major problems identified by Barnes were with the quality of the individual buildings and the willingness of locals to work at the construction of the villages. Thus concerned with the marshalling of labour and its efficacy, Barnes attempted to negotiate exactly whom should be providing what labour input at various stages of construction, and what could be expected of clan members and leprosy patients from the point of view of construction and financing.

At Okuku, the first clinic was held on 9th April 1945, where a temporary shelter had been erected. 90 patients were treated, among an estimated population of 500 leprosy sufferers, and the report notes 'great co-operation'. A visit on 3rd May, with the District Officer Mr. Clarke, led to the conclusion that the village was 'rather near the [Government] rest house', but it was agreed that the site was suitable as long as extension was in the direction away from the rest house.[20] While building carried on, as marked out, on two of the streets leading away from the rest house throughout May, the entry of 17th May notes that:

> The best thing that could have happened to this clinic, did happen, it fell. The carpenter has been fired and the whole shooting gallery moved over to below John Holt's. The lepers will have their water supply from the lower of the two springs, John Holt and the neighbouring village drawing their water from the upper.[21]

It seems then that the admittedly small amount of work that had been carried out at the existing site was ceased, while plans were made to start another village on a new site.

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[20] Village notes - 1945. Okuku. 9th April and 3rd May.

[21] ibid., 17th May. John Holt's refers to one of a network of trading outlets throughout Nigeria - the company has been trading in Nigeria since the 19th century.

However, plans ran into difficulty almost straightaway. The chief on whose land the new site was located told the propagandist sent by the leprologist that he had been absent when the other chiefs showed the spot to the leprologist. He wanted to appoint a new site near the crossroad[22], and was told to seek a decision on this with all the chiefs. Barnes had felt that the original site was the most suitable, and sent out two leprosy officers to see if the chief would change his mind. He refused to do so. The following passage is then entered in the report:

> When this came to the realisation of the L. Officers, and having learnt that he would hardly change his opinion; and seeing that only [one] man in the whole town was [arguing], the site was meant to be taken by force. When the chief understood that however, he immediately changed and gave the site. On explaining his anger, he said that he was neglected by the other chiefs and none informed him that such a place was given to the Leprologist and as such he meant to show that he has also voice in the matter like the other chiefs. He was then congratulated.[23]

It was also pointed out that the leprosy patients would not interfere with his water supply. While site clearing begun soon afterwards, it is not clear from the reports the extent to which the chief in question was to be responsible for this labour.

The next dispute at Okuku dragged on through most of June and July, and concerned building materials and labour. As well as clearing the site for the village, a carpenter needed to be engaged and paid, the materials used in the fallen clinic needed to be transported to the new site, and guarantees of money and labour for building had to be secured. The presence of Mgr. McGettrick on 11th June seemed to galvanise a certain amount of support for the rapid construction of the village. The report states:

> Clearing the stumps & grass and levelling in progress. The old fallen [clinic] loosed and kept ready to be carried to the new site tomorrow. The sum of £12 pounds [sic] was promised by the town and be sending [sic] ten labourers daily till the work is completed. Grass is also to be supplied by the town.[24]

It emerged the next day that this agreement had been reneged upon the moment the Monsignor left. The carpenters arrived and had no means of beginning work, whereupon they reported the matter. On being confronted, the chiefs claimed that they could not afford to provide labour on top of the £12 promised. They agreed instead to pay £20 so that

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22 ibid. The crossroad referred to would seem, from a sketch map with the notes, to be that between the Enugu-Obudu road which passed close to Ogoja, and the Ogoja-Okuku road.

23 ibid. 19th May.

24 ibid. 11th June.

labourers could be hired.

Over the next couple of weeks, it appeared that there had been some misunderstanding as to the role of the labourers. They had been instructed to assist the carpenter in constructing the clinic, for which six of them were paid at the rate of 9d a day. From the village, it was reported that:

> The patients refused to build their houses saying that the chiefs ordered that hence [sic] they have paid the sum mentioned above [£18 of the £20, with the remaining £2 to follow], no one should worry any more for any work in the site. The senior L. Officer with one other L. Officer were sent to the King and chiefs to witness how far that was true. The King & chiefs denied of having...heard of such a thing. They were then advised to pass order to the patients under their charge to go and build their houses.[25]

One week later, the patients were reported to be 'not yet building their houses'.

Furthermore, a dispute had emerged over the ownership of the grass collected for roofing. It was maintained that this had been intended for the District Officer rather than for the leprosy village. When the District Officer claimed that it was of the wrong type, a payment of 1½d. per bundle, for 200 bundles, was demanded if the grass were needed for the clinic. It is unclear whether this was paid, but by the following weekend, it is noted that:

> Tying the clinic roof with palm ribs by the six workers goes on. They have done half-way but all loosed for the fact that the ribs were tied too far apart. [Measurements] given before are to be insisted upon (4½" apart from rib-line to another).[26]

Work on the clinic roof continued to be periodically inspected, but the first reports of patients actually beginning to build their houses didn't come until mid-July. By late July, 12 houses had been started, of which five were judged to be good. More patients were reported to be clearing places.

The decisive moment, both in terms of turning around patient co-operation, and in terms of how the lack of co-operation can be understood and interpreted, came when the receipt of injections was linked to patients 'making strong efforts about building their houses'.[27] This led to appeals for more time so that crops could be reaped. While the reports for Okuku

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25 ibid. 18th June.
26 ibid. 30th June.
27 ibid. 30th July. The entry marked 7th August also mentions a similar tactic, and cites harvest as a complicating factor regarding the release of labour for house building.

preserved in this form end at this time, the combined pressures of labour value and needs, competing demands and expectations regarding responsibility and ownership of materials and products, and the variety of levels of power between colonial, medical and local structures are all intriguingly reflected in this set of notes.

In Mbube, each of twenty towns in the clan area were to build six houses by late May. To ensure that this task was carried out, seven rules were to be put before the Native Council, as follows:

1. Healthy men are to build the house.
2. The lepers if they are strong enough must also help.
3. Those lepers who are not strong enough must see that their townsmen build the houses.
4. No new lepers will get injections unless they have a house.
5. Lepers who are already getting injections must have a house in one month.
6. C.C. [Court Clerk] to call elders and give them list and read out the rules.
7. Any healthy man who refuses to work should be fined by the company but not in court.[28]

The work continued very slowly through June and July, this despite the naming of villages seen to be lukewarm in their contributions to the work, and repeated demonstrations of the cure of leprosy - an injection shed was built, which was infested with ticks, but non-patients seemed loath to work on patient houses, a matter which was referred to Riley later in 1945.

There were difficulties of a more serious degree entirely to be confronted in Abakaliki Division, where demographic instability and political insecurity had forestalled European attempts to establish a strong presence,[29] and undermined Barnes' ambitions to centre the RCM Leprosy Scheme at Abakaliki.[30] The resistance to colonial regulation at this frontier of Igbo migration was manifested in a strong distrust of welfare measures proceeding under a European umbrella, as confirmed in an uncharacteristically irritable outburst from Riley, writing to the District Officer, Abakaliki:

> My view is that since the [RCM] and [CSM] are doing their best so far without Government assistance to fight leprosy for the benefit of lepers and non-lepers alike and have gone to no little expense to date

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[28] Village notes, 1945. Mbube. Before 16th May to 27th July. The quoted passage is at the beginning of the group of notes, but is undated. It precedes an entry for 16th May, and mentions a deadline of 27th May for house building.

[29] See Karmon (1966), pp. 76-77.

[30] Ogoja Convent Files. J. Barnes, 'Leprosy in Ogoja Province'.

> in so doing, the very least the Native authorities and people can do is to turn out a little volunteer labour. The Ezzas are deemed the most virile and progressive clan in Abakaliki, their attitude however reveals them as the most uncooperative, ignorant of the bush wa-was, undeserving of any medical attention whatever. Please tell them this.[31]

In order to overcome the mix of seemingly recalcitrant workers, and uncooperative chiefs, to mediate on issues of ownership, property and access to resources, and to explicate the necessity of addressing infection with leprosy, Barnes resorted to a variety of tactics including threats of official sanction, withdrawal of services, naming and shaming villages, and using the authority of mission and government figures to exact compliance. The variation in responses to these beginnings of leprosy control indicate just some of the social complexity of the area in terms of labour rights and regulations, thought about leprosy, and land resource issues, which were collapsed under the rubric of addressing leprosy and instituting a healthy respect or fear of the disease.

Over the next couple of years, difficulties were reported regarding the attendance of leprosy patients at so-called 'clean' markets, objections coming variously from district officers, clan councils where these existed, and medical mission staff themselves. The nature of the complaints varied, with the sale of food prepared by leprosy patients at local markets, the visiting of these markets by patients, and the rights of patients to set up their own market all exciting concern. Objections were also made at a 1946 inspection to the injection procedures followed at some of the leprosy settlements run by the RCM Ogoja leprosy scheme. These procedures were seen to be in breach of correct practice, resulting in bleeding, faulty sterilisation, and incorrect and wasteful handling of oil.[32] The hygiene and sanitation at some of the outlying segregation villages was seen to be lax, despite some of them being in existence since the early days of the scheme. The inspector communicated his impression that quantity of patients treated had been substituted for quality of treatment at this early and ambitious stage in proceedings.

In 1948, difficulties were reported with the schools - no schemes of work were in place, and

[31] NAE, OGPROF 2/1/2861, p. 15. Letter from P.M. Riley, Resident, Ogoja, to the District Officer, Abakaliki, dated 9th April, 1945, and copied to McGettrick.

[32] Ogoja Convent Files - Inspection notes: Ogoja Province: Roman Catholic Mission leprosy scheme, 3rd-6th June, 1946. Report by T.D. Money. Appendix: 'Administration of hydnocarpus oil: technical errors'

the apparatus for teaching was incomplete. Fines were imposed on the staff for their failure to meet requirements.[33] That this should be the case in the aftermath of the filming of Visitation, which made some play of the centrality of education to the social work of the leprosy scheme, was a matter of some embarrassment to the mission. The teething problems continued with long-running contention of the issue of payment for medical services. While treatment for leprosy was in principle free of charge, the structure of the medical services evolving around leprosy control, encompassing clean clinics and maternity care, and the weakness of record-keeping, made fee structures opaque and left the scheme open to charges of exacting payment for leprosy services. The incomplete distinction between taxation, wage-earning and payment for services and housing made resolution of this issue more difficult still, and it remained largely unresolved while Barnes' structure was in place.

Practical issues in missionary leprosy control – ii) administrative

Queries regarding the issue of payment for leprosy services were made of Barnes by H.J.S. Clark, the District Officer, Ogoja Division in October 1945, following scrutiny of the Osokam [sic] Clan Council minutes, which mention the institution of a new payment regimen for treatment originally assumed to be free, and the practice of allowing patients to remain at their homes upon payment of a £5 fee, which seemed to Clark to contravene proper isolation principles.[34] McGettrick, replying on behalf of Barnes, noted that this fee, payable by wealthy, non-infectious patients wishing to remain at home, was directed to feeding 'the helpless and starving lepers', adding that the Mission would give up this practice 'if Government and local bodies assume a responsibility which really is theirs'. In an annotation to this letter, Clark communicated his impression that the conditions laid down while camps were originally planned placed the responsibility for feeding patients on their families until patients could make their own farms, adding that the scheme would fail if this responsibility

33 Ogoja Convent Files - Ogoja Leper Village School. Supervisor's Report. Inspection dated 19th October 1948.

34 NAE, OGPROF 2/1/2861, p. 50. Copy of letter from H.J.S. Clark, District Officer, Ogoja Division to J. Barnes, RCM Ogoja, dated 1st October 1945.

was allowed to be shirked.[35]

The importance of this principle was reiterated by P.M. Riley, the Resident, Ogoja Province, who commented that it had been agreed that local support of the settlements, which included maintenance of patients until self-sufficiency had been achieved, was a mainstay of the planned scheme, and that the agreed principle of maintenance was in accord with 'recognised Native Custom', and supported by the Criminal Code as a responsibility of heads of families.[36] McGettrick and Barnes, in separate replies to the letters of Clark and Riley, highlighted certain deficiencies emerging from the strict application of principle. Barnes noted firstly that free treatment extended only to Government-supplied chaulmoogra oil, and not to private treatment using privately purchased drugs, offered on request to 'certain well-to-do lepers', and secondly, that the monies collected were due to the poor 'to whom both Church and State owe their very first duty', but for the support of whom no grant application had been made by the Provincial Leprosy Board.[37]

McGettrick, for his part, pointed out the practical consequences of this lacuna in provision: that while the Government should, in theory, be held responsible for the 5% of patients who were destitute and had no one to take care of them, the much larger group who were destitute as a result of family dereliction would none the less starve if the legal route to enforcing duty of support, subject to the 'law's delays', were to be taken by the Mission. Legal recourse might also have the further unintended consequence of encouraging relatives of leprosy sufferers to 'hide [them] at home, and starve them there as they are doing in most cases'. McGettrick proposed that Government force relatives to do their duty, or else support the patients itself, adding that the Mission would periodically send a list of patients abandoned by their relatives.[38]

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[35] NAE, OGPROF 2/1/2861, p. 53. Letter from McGettrick to H.J.S. Clark, District Officer, Ogoja Division, dated 16th October 1945, and annotation from Clark to the Resident, Ogoja Province dated 22nd October 1945.

[36] NAE, OGPROF 2/1/2861, p. 55. Letter from P.M. Riley, the Resident, Ogoja Province, to McGettrick, dated 26th October 1945.

[37] NAE, OGPROF 2/1/2861, p. 54. Letter from Barnes to H.J.S. Clark, District Officer, Ogoja Division, dated 20th October 1945.

[38] NAE, OGPROF 2/1/2861, p. 57-58. Letter from McGettrick to P.M. Riley, the Resident, Ogoja Province, dated 3rd November 1945, endorsed overleaf by Riley to Clark, and by Clark in reply.

That colonial officials gave weight to their responsibilities in this matter, in spite of legal and financial difficulties, can be seen from the endorsements to McGettrick's letter, and from a previous letter from Riley to the Mbube Native Authorities, concerning shortcomings in provision for leprosy control. Both Riley and Clark hoped that the outlines of a method could be evolved to bridge the desirability of maintaining leprosy patients at Mission settlements (in the absence of any legal means to compel patients to stay there) and the onus on families to care for leprosy sufferers, whether at home or in institutions, and that this method could avoid recourse to prosecution.[39] Clark expressed the wish that the RCM would advise him of its difficulties in order to avail of his assistance at the earliest opportunity. This wish was highlighted by difficulties at Mbube, where Riley had written to chastise the Native Authorities over their failure to provide labour for work on the construction of the leprosy settlement 'which the Roman Catholic Mission [were] trying to build', and over objections to the type of house being built. Riley had recommend that the RCM refuse to receive or treat patients from Mbube while assistance with the work was not forthcoming, writing that

> You and your people should be most grateful to the Roman Catholic Mission for what they are doing to stamp out leprosy and you cannot expect the District Officer or myself to help you in other matters while you show by your behaviour that you are not worth helping.[40]

Notwithstanding the implicit threat contained in this passage, and its explicit delineation of power and patronage relations, the negotiation of difficulties regarding the institution of leprosy control was not directed solely by colonial officials and missionaries. Consultation between Riley and the Secretary, Eastern Provinces, demonstrates that Native Authorities also sought clarification on their legal position with regard to leprosy sufferers in their communities, especially in the light of the new RCM leprosy campaign. In response to Native Authority requests for powers to send sufferers to Itu or to local clan settlements, and seeking advice from his superior, Riley suggested a number of solutions under the existing Public Health Ordinance, and other legal instruments, while remaining mindful of the problems posed by legislating for compulsion.[41] The reply indicated that experiences in

[39] ibid.

[40] NAE, OGPROF 2/1/2861, p. 55. Letter from P.M. Riley, Resident, Ogoja Province, to the Native Authorities, Mbube, c/o the District Officer, Ogoja Division, dated 30th October 1945.

[41] NAE, OGPROF 2/1/1790, p. 531. Letter from P.M. Riley, Resident, Ogoja Province to the Secretary, Eastern Provinces dated 7th December 1945.

Owerri and Onitsha Provinces, both under the new Nigeria Leprosy Service and prior to 1945, suggested that if co-operation was not forthcoming, it would be better to wait for the emergence of local desire to co-operate, rather than applying or sanctioning compulsion.[42]

The relation between indigence, payment and discipline, as conceived by colonial officials and missionaries with regard to leprosy patients, was raised again in early 1947, when the medical superintendent for Ogoja Leper Settlement wrote to the Senior Leprosy Officer seeking permission to charge 'a small nominal sum of 3d' for medical treatment other than chaulmoogra oil. The purpose of this charge was to discourage the feigning of illness to obtain medicine to sell at market, a practice which seemed to persist though the superintendent had 'pleaded and reasoned with [patients]'. It was emphasised that the money would pay for the support of 'indigent patients'.[43]

Though no reply to this enquiry is on record, the difference on point of principle it exposes is taken up at a later date, with a letter which, while complimenting the interest shown by the Resident in issues of support for 'poor', 'weak' or 'indigent' patients, highlights the philosophy underpinning the Mission's interpretation of the obligations of the State and of the Mission. Adopting arguments drawn from Catholic teachings on the state and social justice, the correspondent writes:

> It is sometimes argued that the support of the poor is the special province and obligation of the Mission. The truth as we see it is that there is an obligation on us in charity and an obligation on the State in justice, and surely the former, at least in the natural order, is more binding.[44]

adding that 'recognition of present obligations should come before development', and that the poor should receive funds before those rewarded under cost-of-living allowances.

Within the confines of the RCM itself, the principle of payment arose again and again in the broader context of ensuring the continuation and consolidation of the scheme. Though it was conceded that there was theoretically a charge, usually unpaid, for out-patient treatment, it

[42] NAE, OGPROF 2/1/1790, p. 548. Letter from the Acting Secretary, Eastern Provinces to the Resident, Ogoja Province, dated 25th January 1946.

[43] Ogoja Convent Files. Copy of letter from the Medical Superintendent, Ogoja Leper Settlement, to the Senior Leprosy Officer, Oji River, dated 15th April 1947.

[44] Ogoja Convent Files. Copy of letter from the Medical Superintendent, Ogoja Leper Settlement, to the Resident, Ogoja Province, dated 30th April 1947.

was felt that this should not interfere with the treatment of early cases, who would still receive treatment if unable to pay anything.[45] At the same time it was hoped that money made from the 'skin clinics' would provide for the building of a new hospital at Kakwagom, since no mission grant was yet forthcoming.[46]

The relations of trust which had developed between Clark, Riley and Barnes, involving the longstanding support of Clark in ordering and building segregation villages, and Riley's continual assent to and support for the expansion plans espoused by the Mission, did not persist into 1948. Along with a new complement of officials at the Residency and the District Office, and of staff at the RCM Ogoja leprosy scheme, dissatisfaction with the original site and the conduct of leprosy control at one of the most important outlying segregation villages run by the RCM emerged as a crucial cause of conflict throughout the course of the year. Barnes returned to Ireland early in 1948, leaving the leprosy work in the hands of Sr. Dr. Visitation Chambers, a recently qualified MMM doctor,[47] while an acting Resident and assistant District Officer for Ogoja took over from Riley and Clark later in the year.

The complaint raised by the Okundi Clan Council[48] centred around the return to their home villages of patients who had been resident in the segregation village, and were still receiving treatment. The patients had informed the council that they had paid amounts of between thirty shillings and five pounds to be allowed to live at home while under treatment; the council, providing a list of names of such patients, countered that patients should not be returned until they were fully cured.[49] The letter communicating this complaint to the RCM added a complaint by patients resident in the segregation village that many had not received

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45 Ogoja Convent Files. Minutes of meeting of European staff, Ogoja L.S., 5th July, 1947.

46 Ogoja Convent Files. Minutes of meeting of European staff, Ogoja L.S., 24th August, 1947.

47 MMM archives - 1/MMM/1/10. Letter from Martin to McGettrick dated 28th February 1948 notes the 'great pity [Barnes] would not return to Ogoja or Abakaliki and really consolidate the work', and comments on the difficulty of finding a lay male doctor willing to replace him and assist Chambers.

48 This clan council, which represented the Osokum clan, were responsible for the area where the Kakwagom (also referred to in some documentation as the Boki) leprosy segregation village was sited. The council had been referred to by Clark in October 1945 as highlighting the practice of charging for outpatient treatment. The variety of names and titles by which this group were referred to in correspondence, while not in itself a source of confusion to the correspondents, demonstrate the administrative shortcomings arising from historic understaffing of the colonial government apparatus in Ogoja Province in the 1940s.

49 Ogoja Convent Files. Letter from H.J.S. Clark, Senior District Officer, Ogoja Division to the Leprologist, RCM Ogoja, dated 17th May 1948.

injections for three months, as a result of non-payment of a sum of £2:10s. required to construct houses on the proposed new site for the village. On this matter, Clark commented that he had recommended Barnes against moving the site on the grounds that 'he would experience great difficulty in getting the Osokums to turn out and build a second camp', counsel which seemed vindicated by the objections of the patients, many of whom had paid a similar amount for the construction of their current houses. A further difficulty arose from the inability of the Native Administration to finance the building of a road to the new site.

Chambers' reply mitigated the severity of the complaints somewhat, offering a series of interpretations of why and how the issues of contention may have arisen. Again, contending principles of discipline and of concern for the medical interests of patients determined the courses of action taken by the RCM, while the interests of local councils were of less interest to the Mission leprosy staff. Regarding the out-patient treatment of private patients, Chambers referred to the previous agreement between Government and the Mission, which permitted charging for such treatment provided a register was kept.[50] Following Barnes' practice, Chambers reserved for herself the right to decide on the suitability of patients for such treatment, noting that this was not a matter for the Okundi Clan Council.[51]

The rationale for changing site was predicated on the unsuitability of the original site, on an elevated area surrounded by hollows, which limited the scope for house construction by the growing population of the segregation village. The impossibility of determining the comparative effects of chaulmoogra oil and of improved hygiene conditions in attenuating the symptoms of leprosy was offered as a further rationale for developing a site more suitable for the housing of an increased number of patients in prevailing medical and therapeutic circumstances. Chambers chose to present the issues raised by patients refused treatment in the light of these considerations. Noting that the houses built on the original site in 1945

[50] MMM archives - 1/Fou/4(n)/2. Copy of letter from the Department of Medical Services, Lagos, to the Secretary, Eastern Provinces, Enugu dated 22nd February 1946, encloses a copy of a draft of this agreement, entitled *Memorandum of Agreement between Government and the Roman Catholic Mission on the development and execution of anti-leprosy work in the Ogoja Province*.

[51] Ogoja Convent Files. Letter from Sr. Dr. M.V. Chambers to the Senior District Officer, Ogoja Division, dated 2nd June 1948.

were poorly constructed and would have to be torn down in any case, she wrote that patients capable of building houses were allowed and encouraged to do so. With many patients choosing either to pay for the construction of houses, or to provide materials and employ masons and thatchers from Ogoja (where the standard of craft was held to be superior), rather than build their own, the stopping of treatment was to be interpreted as 'a necessary disciplinary measure... in the case of patients who were physically fit to build their houses but made no attempt to do so'.[52]

Replying to a query from Anthony Saville, the new Assistant District Officer for Ogoja Division, in July 1948, which noted 'no further trouble about the new village' in Kakwagom, Chambers detailed the process of registering private patients, both literate and (more usually) illiterate, noting that as well as the registers kept in each village, stating patients' names and addresses, the stage and duration of the disease, the dosage and amount paid, a centrally-held register was kept in Ogoja.[53] She noted that the fees of £3 per adult and 30/- per child (payable in 5s. and 2s. 6d. instalments) were spent on village buildings such as injection and exam. rooms, dressing rooms, wards, offices and nurses' housing, for which no grant was available. The fees of the 88 patients thus treated (in comparison to the 1770 in-patients[54]) were not enough to cover these costs.

Saville's suspicion that the RCM may have never actually sought Government permission to charge under the cited section of the agreement between Mission and Government[55] was amplified following a November 1948 tour taking him to Okundi, where he heard the renewed complaints of the clan council and the leprosy patients. Patients complained that the

[52] ibid.

[53] Ogoja Convent Files. Letter from Anthony G. Saville, Assistant District Officer, Ogoja Division, to the Medical Superintendent, Ogoja Leper Settlement dated 26th July 1948. NAE, OGPROF 2/1/2861, p. 170. Letter from M. Chambers, Medical Superintendent, Ogoja Leper Settlement, to the District Officer, Ogoja Division dated 10th August 1948. Chambers reply draws a distinction between the contaminated registers held at the villages, and the copy held centrally in Ogoja.

[54] Ogoja Convent Files. Letter from Sr. M. Anna[?], Ogoja Leper Settlement, to Fr. McManus, RCM Afikpo dated 11th August 1948, lists a total of 1770 in-patients in the villages of Ogoja, Okuku, Abuochichi, Mbube Irruan, Kakwagom and Obudu, on 1st July 1948, compared with 1116 (1613 including Abakaliki and Ngbo) on 1st January 1948. Her letter expands on the thesis of contaminated registers, noting that compilations of admissions, discharges and deaths could only be compiled when tours to all the villages had been completed, implying that the registers could not be brought to the office in Ogoja.

[55] NAE, OGPROF 2/1/2861, p. 169. Letter from A.G. Saville, District Office, Ogoja to the Resident, Ogoja Province dated 12th August 1948.

Sisters had not visited either the new or old villages in the previous few months, and that patients who had not paid the sum for house construction were not allowed to build their own houses, even in conformity to prescribed house plans. It was felt that private patients received preferential treatment, even as the Clan Council objected to the dilution of segregation principles implied by out-patient practices. Given the attentiveness of RCM Fathers and catechists to their spiritual needs, in contrast to the medical attention received, patients felt that 'they [were] assembled rather for conversion to Roman Catholicism than for the treatment of their leprosy... Their souls apparently are to be saved, though their bodies may rot.'[56]

The existence of a private dispensary at Emanduk, to which the Sisters travelled through the Kakwagom village, proved another point of contention. The RCM were said to be using a Government Rest House without permission as a dispensary, where injections for gonorrhoea, yaws and other skin-related conditions were sold, along with bandages and dressings, to patients drawn from Ogoja, Obubra and Ikom Divisions. It was charged that no records were kept or diagnoses attempted at this clinic, and that dissatisfaction at 'inflated payment' for RCM leprosy work, education and proselytisation was widespread across Ogoja Division, a situation exacerbated by the fact that 'no one has ever yet been able to see a balance sheet produced by the Mission.'[57]

Though a note was made that these charges against the RCM were being investigated by both the Resident and the Senior Leprosy Officer,[58] the most serious charges, that the RCM profiteered from private practice at the expense of segregated leprosy patients, and that evangelism was either forced or conducted in preference to leprosy work, seem never to have been substantiated. Saville, in a subsequent posting to Obudu, seemed amenable to working with the RCM in the area,[59] while the only specific complaint directed to the RCM Leprosy

[56] NAE, OGPROF 2/1/2861, pp. 175-76. Letter from the District Office, Ogoja to the Resident, Ogoja Province dated 15th November 1948.
[57] ibid.
[58] ibid. A number of handwritten notes to this effect were appended at the base of the letter.
[59] NAE, OGPROF 2/1/1790, p. 677(b). Letter from A.G. Saville, Assistant District Officer, Obudu District to the Resident, Ogoja Province dated 29th December 1948. This correspondence deals with the construction of feeder roads to leprosy villages, and makes no adverse comments about the expansion of RCM leprosy work in the area.

Scheme dealt with the unauthorised use of Government buildings, and received the reply that explicit consent would be sought in the future, and that the verbal permissions applying to a small number of such buildings would no longer be assumed by the Mission to cover all Government buildings by extrapolation.[60] The existence of the dispensary clinics would later be explained by McGettrick as 'part and parcel of the leprosy campaign... instituted to discover early cases',[61] but the fact remained that until 1949 the accounts and statistics kept by the RCM Ogoja leprosy scheme were scant and largely unspecific as to the sources of income.

From the perspective of funding, the question of finance also preoccupied administrators of leprosy control in Ogoja. While BELRA, for their part, were originally loath to grant money to the planned RCM Ogoja Leprosy Scheme,[62] the accounts of the Scheme for 1946-47 show a grant of £1,020 from BELRA for equipment for a laboratory, a hospital and clinics, as well as for a kit-car for transport, in spite of Barnes' unwillingness to carry out the leprosy survey which had originally been a condition of assistance. The softening of BELRA's position on this matter is of a piece with its perceived position with regard to evolving British imperial policy on Colonial Development and Welfare. Following the recommendation of the International Leprosy Congress in 1938 that leprosaria should pass from voluntary agencies into government hands, BELRA was concerned that its resources not be exploited as an excuse to limit government funding of leprosy control. As a result, BELRA indicated its intention to focus primarily on what it referred to as pioneer efforts, an aim attested to in a memorandum reproduced in its Annual Report of 1945. This complemented an accompanying assertion that:

> the relief of leprosy is only partly a medical matter; the environmental influences, social, educational and spiritual, are no less important, and for these BELRA and the missions will still furnish staff and

[60] Ogoja Convent Files. Letter from H. West-Pierce, District Officer, Ogoja to Dr. Chambers, Leprosy Supt., RCM Ogoja dated 1st December 1948, and letter from Chambers to West-Pierce dated 10th December 1948.

[61] Ogoja Convent Files. Letter from McGettrick to Senior Leprosy Officer, Oji River dated 4th May 1949.

[62] Nigerian National Archives, Enugu (NAE), OGPROF 2/1/1788, p. 148. Memorandum from the Director of Medical Services, Lagos to the Senior Health Officer, Eastern Provinces, Enugu, dated 19th March 1940, endorsed to the Resident, Ogoja on the 25th March, 1940. The endorsement asked that McGettrick be informed of the decision of the Nigeria branch of BELRA, meeting on 9th Mar 1940, not to approve a grant to the Ogoja Provincial Leprosy Board. This decision was reached on the grounds that a detailed plan of work had not been submitted.

equipment.[63]

This would be coupled with the opening of a BELRA Nigeria Committee, mooted for 1947,[64] the development of its research capacity in Uzuakoli, and its central position in the development of the national Leprosy Control Board.

The scope of the BELRA Child Adoption Scheme, begun in a small way just prior to World War Two, became at once more ambitious and more highly organised from 1947. It was noted that:

> The claim of children to priority of consideration in treatment is unchallenged no less because they offer the best point from the medical angle of attacking the disease than because of the natural desire to give the rising generation a fairer chance in life.[65]

The centralisation of this programme after 1947 allowed the payment of block grants to Leprosy Settlements, placing less of an administrative onus on the settlements themselves, and was extended to Ogoja for the first time in 1949, in the wake of a successful campaign for more sponsors which involved the British Royal Family. BELRA also controversially provided sulphetrone to Ogoja in addition to the Nigerian Government supplies of dapsone.[66] By 1955, 389 of BELRA's 2134 adoptees in Africa were in the RCM's northern Ogoja settlements, a proportion which grew throughout the 1950s to reach 789 of 2799 adoptees by 1961.[67] This was to give to the RCM Ogoja Leprosy Scheme a measure of the security it had so dearly sought in its early years.

It would not, however, dissolve the variety of political disputes over land and land-holding to which the RCM found itself party. Running concurrently with disputes over issues of charging, financing and fees were a series of questions over boundaries of leprosy villages and adjoining lands, and the development of market facilities for the villages. The concerns of the Okundi Clan Council over the incomplete segregation of patients at Kakwagom, and the preferential treatment accorded to private leprosy patients is echoed in the attention given to the issue of access to markets for leprosy patients. The Sanitary Overseer and the Medical

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63 *British Empire Leprosy Relief Association. Annual Report*, (1945), pp. 4-6.
64 *British Empire Leprosy Relief Association. Annual Report*, (1946), p. 7.
65 *British Empire Leprosy Relief Association. Annual Report*, (1946), p. 8.
66 See Chapter Six.
67 *British Empire Leprosy Relief Association. Annual Report*, (1956), p. 8, and (1961), pp. 10-11.

Officer for Ogoja wished it to be communicated to the RCM leprologist that the 'undesirable practice' of leprosy patients preparing yam fou-fou and sending their children to market with it should be prohibited.[68] In Obudu, a deputation from Clan councils at Abakpa, Obudu and Obanliku complained that:

> about 50 lepers attend the Obudu market and mix freely with the clean people. They pick up meat and they do not buy it, thus spreading disease... Obudu people are in complete ignorance of the cause of the disease, and the healthy and unhealthy live, eat and sleep together, thus spreading the disease further.[69]

This deputation called for the enforcement of segregation by chiefs in special compounds, the opening of special villages and a special market for leprosy sufferers, and the ending of access to Obudu market by leprosy sufferers.

The Senior District Officer for Ogoja Division suggested the opening of a small market near the main Ogoja Leprosy Settlement as a subsidiary to the main Ishibori market in Ogoja as a means of ending 'the habit [of leprosy patients] of frequenting the Ishibori market in large numbers',[70] a question which Barnes had been anxious to discuss with the colonial administration,[71] especially in the light of the illicit sale of medicines by leprosy patients at the market.[72] In response to renewed criticism of the conduct and sanitation of Ishibori market in early 1948, the responsibility for the majority of breaches laid at the door of leprosy sufferers assumed to be patients at RCM Ogoja Leprosy Settlement, the Mission outlined its longstanding arrangements for a market to be held in the Settlement, pointing out that this arrangement had at first caused conflict with the marketers in Ishibori, and that the Mission was doing all in our power to prevent patients leaving segregation villages to attend markets.[73]

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[68] Ogoja Convent Files. Letter from A.W. Colin, Assistant District Officer, Ogoja Division to the Leprologist, RCM Ogoja dated 11th November 1946.

[69] Ogoja Convent Files. Letter from the Assistant District Officer, Obudu to the Doctor-in-Charge, RCM Ogoja dated 11th February 1947. The charge of ignorance is quoted from the deputation, rather than concluded by the correspondent, while the charge of attendance at the market by leprosy sufferers is said to be corroborated by Police Intelligence Reports.

[70] Ogoja Convent Files. Letter from the Senior District Officer, Ogoja Division to Dr. Barnes, Ogoja Leper Settlement dated 3rd April 1947.

[71] Ogoja Convent Files. Letter from Ogoja Leper Settlement to the Senior District Officer dated 14th April 1947.

[72] Ogoja Convent Files. Letter from the Medical Superintendent, Ogoja Leper Settlement to the Senior Leprosy Officer, Oji River dated 15th April 1947.

[73] Ogoja Convent Files. Letter from Ogoja Leprosy Settlement to the Senior Leprosy Officer, Oji River dated 13th January 1948.

The specific nature of the problems with market attendance and reorganisation were aired later in the year, when the complaint of the medical superintendent for the RCM Ogoja leprosy scheme was raised, that

> the local chiefs will not let anyone sell [at the special market for the lepers] unless they are suitably and regularly rewarded [and] if she tries to arrange for one or two persons to make purchases for the lepers, they insist upon getting a commission which the lepers are not prepared to pay.[74]

As with much in the early days of the RCM Ogoja Leprosy Scheme, the physical boundaries of the individual leprosy settlement remained undefined. Barnes explained to the dissatisfied Senior Leprosy Officer that he

> considered it a mistaken policy to [ultimately define colony boundaries] at the very beginning before we had accurate information as to the number of lepers in each clan and the number of acres required for the maintenance of each individual.[75]

By mid-1947, the 'problem of boundaries' could no longer be ignored, and had become pressing in Okuku, the nearest subsidiary settlement to the central one in Ogoja,[76] prompting Barnes to canvas opinion on the ideal maximum isolation village size and the required acreage.

From Ossiomo in Benin Province, K.S. Seal, relieving Dr. Lengauer, wrote a considered response balancing the proportion of able-bodied patients with the farming requirements, taking into account local crops and land type, stressing the reliance on properly trained local nurses for ensuring the success of a village, and concluding that no more than around 250 people should be housed in any one village. He noted that at Ossiomo, each patient was granted a 3.5 acre plot, farmed in rotation over 7 years, but that ultimately, the extent of a settlement was determined in co-operation with local chiefs.[77] McKelvie, at Oji River, was similarly cautious in hedging the advice that 150-200 was an optimum population size, noting that their practice was to provide 2/3 acre plots on a 4 year rotation.[78] T.F. Davey, writing from Uzuakoli, confused the issue by specifying 3 acres per person, but giving area-

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[74] NAE, OGPROF 2/1/2861, p. 169. Letter from A.G. Saville, Assistant District Officer, Ogoja Division to the Resident, Ogoja Province dated 12th August 1948.

[75] Ogoja Convent Files. Letter from J. Barnes to the Senior Leprosy Officer, Udi, via Enugu, dated 29th August, 1947.

[76] ibid.

[77] Ogoja Convent Files. Letter from K.S.Seal, Nigeria Leprosy Service, Ossiomo Settlement, to J. Barnes, dated 22nd September, 1947.

[78] Ogoja Convent Files. Letter from A. McKelvie, Oji River, to J. Barnes, dated 6th September, 1947.

population figures which corresponded to 1 acre per person, an oversight wryly annotated by Barnes.[79] A further reply from Oji River contended that

> the number of patients is controlled by the ability to maintain discipline. All the patients in the clan should be in the Segregation Village. If clan discipline is lax, it will be necessary to augment it with European supervision. If this European supervision is thorough, the segregation village ceases to be worthy of the prefix 'clan' and becomes virtually a daughter settlement.[80]

From the original sequence of village visits and attempts to ascertain the likely success, staffing resources, and local compliance the mission would meet in a given community, to the decision to assign a regimented and bordered space within community lands to leprosy patients, the RCM Ogoja Leprosy Scheme was implicated in local discourse about land, borders, and entitlement. The explicit linking of compliance – read as the desire to address and commit local resources to leprosy issues – to the extension of mission welfare input is epitomised in the reflections on 'clan' discipline outlined above. This gave the mission a potent role as arbiter in a variety of land and resource disputes, and encouraged and fostered new ways of thinking about the fixity and legal status of land use throughout the colonial province.

Within the especially narrow horizons of the colonial administration in Ogoja as beacon of development planning, the interventions of the RCM Ogoja Leprosy Scheme loomed large, as was demonstrated in 1950, when V.K. Johnson, the Resident for Ogoja Province commended the rural development efforts being made by Barnes in the various villages attached to the leprosy scheme. Following the First Provincial Staff Conference, held at Abakaliki in August of 1950 to consider the Community Development Programme for the Province, Johnson wrote to Barnes to inform him of the progress of the meeting, and to secure his assistance in propagandising for a Community Development 'movement', stating that

> nowhere in Nigeria is there such a remarkable opportunity open to us to get such a movement started, as in [Ogoja]... There is, in fact, no field of human activity which could not be improved by community development, or in simpler terms, by the spirit of self-help.[81]

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79 Ogoja Convent Files. Letter from T.F. Davey, Uzuakoli, to J. Barnes, dated 10th October, 1947. Barnes adjusted the figures provided in the margins of the page.

80 Ogoja Convent Files. Letter from Central Leprosy Unit, Oji River to J. Barnes, dated 9th October, 1947.

81 Ogoja Convent Files. Letter from V.K. Johnson, Resident, Ogoja Province, to J. Barnes, dated 18th September, 1950, enclosing a copy of the minutes of the First Ogoja Provincial Staff Conference, 29-30th

Appended to what was effectively a circular to the Europeans working in Ogoja, calling on them to encourage community and co-operative effort, was a handwritten message to Barnes, noting:

> You are, of course, already doing commu[nity] development work in a big way, but I wanted to keep you and your wife in the [know,] so have addressed this letter to you which is the sam[e as] to others.[82]

Barnes was pleased at the recognition accorded his leprosy-related development work, detailing a number of initiatives than might accord with and inform official policy:

> Apart from village planning and sanitation, which I trust are taken for granted, we also conduct evening classes at our Centre here in Ogoja and at Kakwagom Leper Village, stage Concerts on big occasions, encourage football for the school children, and attempt brick making.[83]

He had long nurtured the notion that leprosy control might provide a spearhead for the inculcation of development ideals in an area with such a high notional prevalence of the illness, as outlined in a 1947 position paper he had presented to Johnson's predecessor, P.M. Riley. In a telling meditation on the spatial re-organisation occasioned by the building of a leprosy village, and on the potential ramifications of this process for the society at large, Barnes outlined his core principles regarding leprosy and its control:

> The leper community has been uprooted from its traditional milieu and expects a new mode of life, and is prepared in the hope of cure to adapt itself. None the less, the policy should be one of development rather than change, a growth based on traditional customs and native industries. This flexibility I should think compares very favourably with the resistance and conservation [sic] of the general community. Habits once acquired in the colony are deeply ingrained especially when they pay well.[84]

He contrasted the leprosy colony with bureaucratic government development schemes, which were held to reward the well-trained and able-bodied and to create civil servants, and pointed out that government support of the colonies envisaged by Barnes would save money, inculcate practices of hygiene, and help those among the most impoverished in any community,[85] endowing them with technical abilities which could be exercised to commercial ends upon discharge from the colony.

While the practical effect of the 1950 Community Development moves was to stream

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August, 1950.

82 ibid. The corner of this page is not legible, but the remainder preserves the sense of the message.

83 Ogoja Convent Files. Copy of letter from J. Barnes to the Resident, Ogoja, dated 27th September, 1950.

84 Ogoja Convent Files. Letter from J. Barnes to the Resident, Ogoja, dated 26th July, 1947, enclosing a paper entitled 'Farming Industrial Leper Colonies'.

85 ibid. Barnes notes that 'the lepers, after the insane, are the most neglected element in this society.'

additional money towards the development of feeder roads into leprosy villages, and to underwrite some of the capital costs which had been omitted under the headings of the 1940 Colonial Development and Welfare Act,[86] the understandings of development planning in the context of the RCM Ogoja Leprosy Scheme had distinctly charitable and communitarian overtones. Commending local principles of land tenure,[87] and vaunting craft and technique, Barnes sought to universalise the experience of leprosy patients, and to abstract from it a set of developmental principles which would commend colonial government to the population to which it was held to be responsible.

The proactive role of the RCM in community intervention, employment, and land use policy endowed it with a strategic role in the extension of the colonial administrative remit in Ogoja. The notions of co-operation and compliance implied in self-help principles encouraged local recourse to the mission in the courting and seeding of development projects, and inventive responses to disputes between neighbouring groups. To gain some idea of what was at stake in efforts to control leprosy, the investigation must turn to consider the nature of the medical response to the disease mounted by Catholic missionaries in Ogoja.

86 T. Falola, *Development Planning and Decolonisation in Nigeria*, (Gainesville, 1996), ch. 3.

87 Barnes, 'Farming Industrial Leper Colonies', noted that the Ogoja land tenure system 'seems to strike the happy but difficult balance between private and public enterprise which avoids mistakes of extreme right and left, America or Russia.'

Chapter Six - Catholic medical enterprise in Ogoja, 1945-1953

> Whether the approach is empirical or rationalised... the imagination of the investigator is as in all research work a very important factor. The 'hunch' or inspired guess always remains outside the theory as perhaps the most valuable tool of the worker.[1]

Whereas the spiritual dimension of missionary leprosy work in Ogoja translated Irish Catholic understandings of duty, charity and welfare into a colonial setting, and infused the bureaucratic dimension of leprosy control in Ogoja with an expressly Catholic critique of organisational method and staff-patient-community relations, from the point of view of medical and clinical approaches to leprosy, the Ogoja Leprosy Scheme was closely aligned with both Nigerian and international patterns and developments in leprosy control. Both in its application of the institutional leprosy control techniques developed in the post-1936 Eastern Nigerian context, and in its eager evaluation and adoption of chemotherapeutic advances piloted abroad and in Nigeria, the Ogoja Leprosy Scheme demonstrated scientific and clinical aspirations and allegiances very much in keeping with mid-twentieth century theory and practice in medicine and public health.

Previous chapters have explored the salience of distinctions between Catholic thought and practice and colonial administrative methodologies, the problematic, though often fruitful interaction between these discursive formations in the context of medical administration, and the implications of these interactions for leprosy control strategy and propaganda. In what follows, I draw attention to the technical bodies of knowledge which grounded the practice of Catholic missionary medicine in Ogoja Province. These bodies of knowledge, and the discourses surrounding their application in the contexts of Ogoja and of Eastern Nigeria more broadly, delineated technical and rhetorical fields for the discussion of leprosy. Assent to and engagement with these fields united colonial and missionary actors alike. Examining the mechanics by which a sense of common purpose among those concerned with leprosy

[1] Vincent C. Barry, 'Antitubercular compounds: presidential address', in *Irish Chemical News*, (Winter 1997), p. 45. This is a reprint of a 1946 address to the Irish Chemical Association, (later the Institute of Chemistry – see URL: http://www.instituteofchemistry.org/history.htm – last consulted, June 2004)

control was elaborated and underpinned, this chapter describes the language and application of technocratic expertise which stabilised and entrenched the Roman Catholic missionary stake in the politics of late-colonial Ogoja Province.

More specifically, this chapter situates the prevalence of leprosy in Ogoja in its epidemiological context as understood by colonial medical personnel, examines the ramifications of segregation-based leprosy control policy for understandings of community welfare and for development and adoption of new disease control techniques, and explicates in detail the context and contribution of chemotherapeutic research carried out by RCM medical staff in Ogoja in the context of broader advances in technologies of leprosy control. In this way, I develop an investigative model describing local articulations of global and universalising discourses which derive from the context of twentieth century biomedicine. In sum, expanding my account by way of reflection on the course of clinical and research practice at the margins, I seek to make sense of ostensibly unconventional global linkages, which at the same time seem to permeate the science and practice of leprosy control throughout the twentieth century. In situating an often exotic historiography of leprosy in its biomedical context, and describing leprosy control as one set among a much broader raft of social and medical interventions, I arrive at a more powerful and wide-ranging analytical context to aid in determining the significance of Catholic leprosy work in Ogoja Province.

Leprosy control, maternity care and general medicine in Ogoja Province

> Betty Barnes - We had an outbreak of smallpox which was a very frightening thing... schistosomiasis had arrived... you said it didn't exist there...
>
> Joe Barnes - And there was one area, certainly, where guinea worm was quite common... filaria... Various forms of [filaria]...
>
> Betty Barnes - But it was the malaria, malaria, malaria, wasn't it?
>
> Joe Barnes - Ah yes... definitely... Leprosy, TB, malaria, malaria, diarrhoea, diarrhoea, diarrhoea...[2]

The above exchange, prompted by my enquiry into which illnesses, aside from leprosy, were

[2] Author's interview with Joe and Betty Barnes, Royal College of Surgeons, Dublin, 27th March 2000.

commonly to be found in Ogoja, provides an encapsulation of the pattern and scale of health problems encountered by the RCM in its early medical work in Ogoja Province. Reference to frightening outbreaks of incurable disease, to seemingly new diseases introduced by recent demographic shifts and migration patterns, to geographic locales in which various conditions predominated, to ostensibly massive underlying health problems resulting from parasitic infections and endemic malaria, and to a set of chronic conditions such as leprosy, affecting large proportions of the population, are all to be found in this account.

The use of word repetition in the quoted passage, as a shorthand for prevalence, sketches in outline the epidemiological context of leprosy control work in Ogoja Province. The area around Obudu was noted for a relatively high annual incidence of trypanosomiasis, and was subject to the attentions of the Sleeping Sickness Survey; figures derived from this survey were made available to Barnes in late 1944 and early 1945.[3]

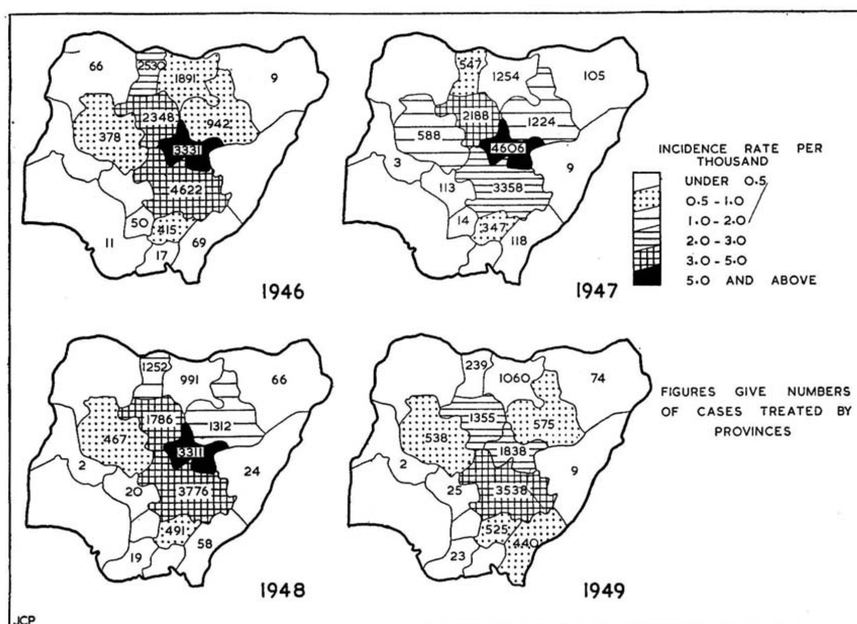

FIG. 31. TRYPANOSOMIASIS

Incidence in recent years. The Provinces most severely affected—Katsina, Zaria, Plateau and Benue—stand out clearly.

Map 8: Incidence of trypanosomiasis in Nigeria, 1946-49[4]

Guinea worm flourished in the impermeable soils near Abakaliki, where seasonal rainwater

[3] Ogoja Convent Files. Letter from J.L. McLetchie, Sleeping Sickness Survey, to the Resident, Ogoja Province, dated, 24 February 1945.

[4] Buchanan and Pugh, (1955), p. 48. Ogoja is the province marked '415' in 1946.

was stored in specially dug pools,[5] and schistosomiasis had begun to make inroads along the seasonal riverine trade routes across the province. All three diseases had been traditionally the subject of large-scale colonial environmental interventions, and as such, medical workers were habitually attuned to their occurrence in any given area. Familiarity with the local epidemiological terrain inevitably uncovered a consistent substrate of malaria and gastro-enteric disease, and these, allied with goitre and chronic hepatic illness,[6] constituted the preponderant burden of illness on communities in Ogoja Province.

A small, but growing incidence of tuberculosis, conventionally linked with the return of soldiers from World War Two,[7] did not seem to present a major public health problem in Ogoja Province in the late 1940s. However, in common with other medical establishments run by Catholic missionaries, local birth and midwifery practices were seen as requiring attention and intervention, and related complications frequently vied for the attention of medical staff ostensibly preoccupied with leprosy control. The establishment of maternity Units at Kakwagom and Ogoja, and moves to establish general hospitals at Obudu and Ikom are testament to the realisation that treatment of leprosy would need to be undertaken in concert with a variety of other forms of medical, surgical and social intervention, as has been demonstrated with reference to increased role specification and differentiation among mission staff over the early years of the RCM Ogoja leprosy scheme.[8] This process substantiates the intuition recorded by Muir in 1936 that leprosy, as a 'key disease',[9] could act as a bridgehead for the establishment of general medical services.

The dialectic between the exigencies of nationally-conceived strategies for leprosy control, and the extensive variety of needs discerned by missionary medical personnel among communities which had been without the extension of European medical services already

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5 Y. Karmon, *A Geography of Settlement in Eastern Nigeria*, (1966), p. 49.

6 The very high incidence of cirrhosis and hepatic disease in Ogoja was noted in E.J. Allday and J. Barnes, 'Treatment of leprosy with B.283', in *Irish Journal of Medical Science*, Sixth series, No. 322, (Oct 1952), p. 424, where 36% of schoolchildren associated with the leprosy settlement were claimed to have enlarged livers, while an attribution a 40% prevalence of hepatic illness among leprosy patients to methionine deficiency was made in a meeting of the European staff of the Ogoja Leprosy Settlement on 7th June, 1947 (Ogoja Convent Files).

7 Author's interview with Dr. Joe and Betty Barnes.

8 See Chapter Four

9 See Chapter Three

apparent in much of Eastern Nigeria, greatly exercised the ideologues of Roman Catholic missionary medicine in Ogoja Province.

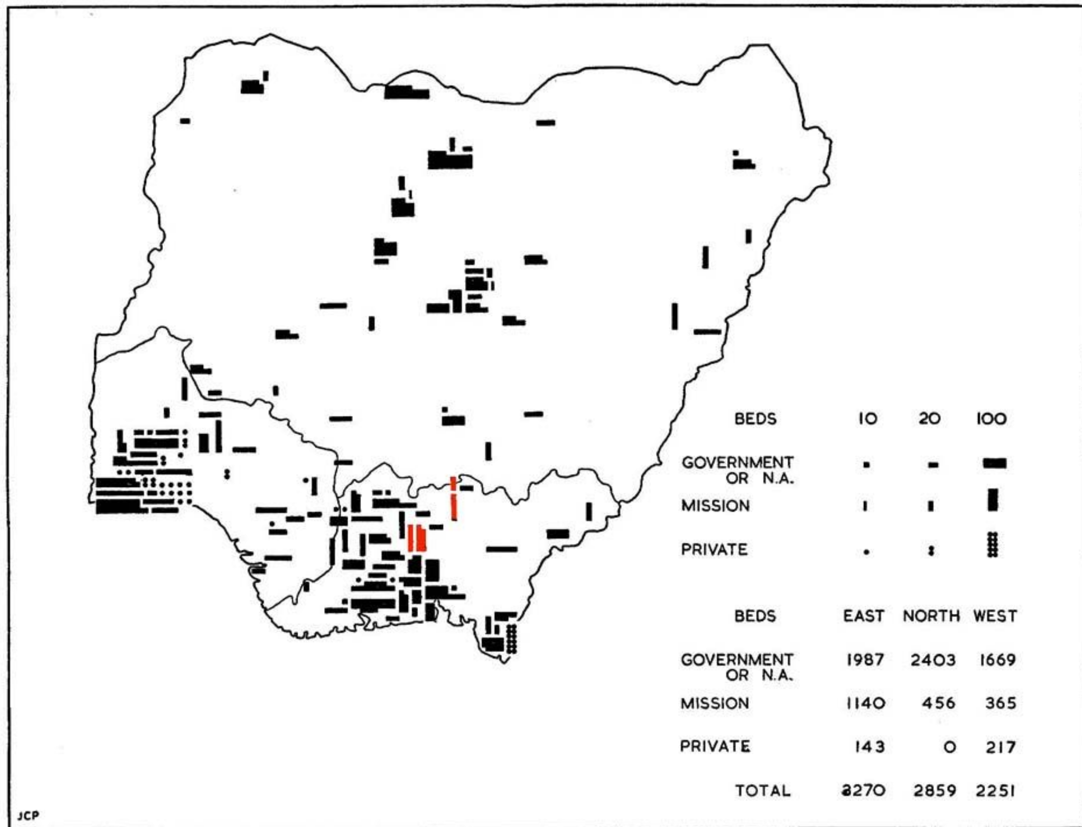

FIG. 167. HOSPITALS

Map 9: Hospitals in Nigeria – location, management, and size, 1955[10]

The notion that one could grow and tend leprosy services, that they would somehow organically approximate to the results and coverage of a more thoroughly planned and implemented model adhering to Muir's strategy, was especially dear to Barnes, and greatly invigorated the development of the young RCM Ogoja leprosy scheme. Indeed, Barnes presented his plans as the most viable means of implementing a clan-based strategy of the type envisaged by Muir in what was envisioned as the impenetrable obscurity of the Ogoja bush.

Thus Barnes' insistence that a survey of leprosy incidence would have been a meaningless undertaking in Ogoja Province in 1945: this, as has been intimated, was undergirded by the

[10] Buchanan and Pugh (1955), p. 231. I have highlighted in red what seem to be RCM establishments at Abakaliki, Afikpo, Ogoja, and Obudu – the placement of the bars does not correspond exactly to the location of hospitals in the area.

assumption that complete coverage would eventually and naturally result from the organic, piecemeal growth of a well-worked out scheme for leprosy control. Barnes and the RCM imagined that, given the technical achievements of comprehensive identification of the clans to be assisted, and correct recognition of the boundaries of these clans, the slow development of a complete infrastructure for leprosy control should guarantee the eventual tracing and treatment of all cases of leprosy in the area of coverage.

The identification of patients, the negotiation of spaces with access to resources and in proximity to patients' families, and the isolation of patients in these designated and policed spaces were therefore seen as the main tasks facing the RCM Ogoja leprosy scheme in its earliest incarnation. The increasing obsolescence of the treatment methods underpinning these principles did not translate to an attenuation of these spaces in the short run - indeed, the leprosy village itself was endowed with new functions as rehabilitative and curative therapies in leprosy were transformed. The ideologies framing interventionist and land-extensive models of leprosy control, made manifest in the village, proved strikingly persistent, even in the light of advances in outpatient capacities.

The development of ancillary skin clinics and other medical services, as proposed by Martin in her 1947 visit to Ogoja, and implemented by the MMMs in combination with Barnes' focus on leprosy control, communicates an appreciation of the strategic potential of leprosy as a bridgehead for medical services, as well as giving some idea of the complexities attending treatment and diagnosis of diseases in tropical settings. The reliance of the RCM medical network in late-colonial Ogoja on the framework of the leprosy service helped to ensure that the evolution of leprosy villages had a significant impact on missionary development ideologies regarding capacity-building and welfare services, and that this evolutionary process acted as a pragmatic stand-in for more thoroughgoing, 'scientific' methodologies of disease control. In effect, for Ogoja, the institutional overheads generated by the pragmatic means employed in leprosy control had a conservative political impact on the politics both of local administration and of mission and religion.

Subject to inspection: early difficulties with medical administration

Evidence of the difficulties encountered in attempting to establish leprosy control in Ogoja Province can be divined from colonial government commentary on the medical side of the RCM leprosy scheme. T.D.F. Money, the Church Missionary Society doctor from Oji River seconded to the Nigeria Leprosy Service as Senior Leprosy Officer, concluded a damning report on the progress of the RCM Ogoja leprosy scheme on a June 1946 visit to a number of segregation villages across the area of operations of the scheme. Noting verbal recommendations made to Barnes at an earlier visit in January 1946, when Money judged the scheme to have been at too early a stage to set his criticisms on record, he set out the extent to which government had already funded the development of the scheme, and, further, the extent to which this development accorded with the original plans. He observed that

> the construction of the major Segregation Villages has been carried out to varying degrees in each Division and a number of minor Segregation Villages are also in construction. At the same time as construction proceeds a considerable number of patients have come into residence.[11]

In respect of this observation, Money adjudged the development of the scheme to have been too hasty, over-reaching its planning capacity, and thus based on insecure and substandard foundations.

He identified the 'undefined proceedings'[12] for arranging land use, citing the direct approach of the mission to landowners often, it was alleged, without the assistance or approval of District officers, the poorly defined borders and indeterminate relation between prospective number of patients and size and extent of plots available, and the seeming disjuncture between the catchment area for admissions to a village and the boundaries of the native authority responsible for the land grant. The imprecision of village layout plans, seen as crucial for at least the larger villages, and the 'wasted effort' expended in the construction of

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[11] NAE, OGPROF 2/1/2861, pp. 86-88. Report dated 15th July 1946, on the visit of T.D.F. Money, Senior Leprosy Officer, Nigeria Leprosy Service to Ogoja Province: Roman Catholic Mission Leprosy Scheme from 3rd to 6th June 1946. Paragraph 3.

[12] ibid., paragraph, 4.1.i.

non-native rectangular style houses[13] were discouraging, while Money found the lack of sanitary arrangements in all but the Ogoja main segregation village, in spite of the several months residence of many of the patients, worthy of particular opprobrium, pointing out that 'the patient [was invited] to cover his excreta in the bush.'[14]

Money's most serious objections to procedures at Ogoja centred on the injection regimen. As a result of poor extant practices for recording diagnosis, progress and treatment,[15] the dosage of chaulmoogra oil, routinely injected intradermally at Ogoja,[16] was often badly administered by unsupervised and unlicensed practitioners. The terms of apprenticeship for injectors did not seem to be being followed, while dosage was not adjusted 'for months at a time',[17] the weekly total amount to be administered being split into five doses, administered on separate days 'to persuade the patients to remain in the villages'.[18] This latter pattern seemed to Money to be insupportable as a method of securing discipline. Coupled with the shortcomings in maintaining sterilised skin, needles and solution, in conserving scarce oil supplies, and in managing to inject intradermally, as opposed to subcutaneously, often provoking bleeding,[19] the scattershot injection regime seemed to represent an especial waste of effort and resources, encapsulated in the remark that 'the lessons to be learned from older established work... have not been assimilated, or that quantity (number of patients) is deliberately placed before quality'.[20]

Money's recommendations comprised a number of organisational solutions to arranging land use and agreeing boundaries, designing villages and admitting patients, recording and reviewing diagnosis and treatment, extending the provision of bacteriological exams, and improving and supervising therapeutic techniques. He mandated that no further licenses be

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[13] ibid., paragraph 4.1.iii. Money notes that the 'native style of construction is a round house... Where the [rectangular houses, considered better by the doctor-in-charge] are constructed by the Mission the result is satisfactory but where a patient attempts a rectangular house it frequently is not.'
[14] ibid., paragraph 4.1.iv.
[15] ibid., paragraph 4.2.i notes that 'diagnostic and progress records are virtually non-existent. Neither are the occasions of treatment recorded.'
[16] ibid., paragraph 4.2.iii.a records Money's opinion that he 'should not expect much result from injections confined to the intradermal route.'
[17] ibid., paragraph 4.2.iii.a.
[18] ibid., paragraph 4.1.v.
[19] ibid., appendix, 'Administration of hydnocarpus oil: technical errors'.
[20] ibid., paragraph 6.

granted, except to Sisters, and no expansion be undertaken, either in number of villages or of residents, until further inspection had confirmed that standards had risen. Noting that the work being carried out represented a significant contribution in European personnel for African welfare, he signed off with the contention that 'nevertheless Government cannot be indifferent to the quality of the work performed.'[21]

Though Money's report seems not to have been received by Barnes until the following May,[22] it overshadows much of the official correspondence in the intervening months regarding the development of the RCM Ogoja leprosy scheme and the deployment of its staff. Barnes' plans to develop leprosy control in the area of the Cameroons under British trusteeship,[23] presented to Money in search of advice, were not regarded favourably given the reported deficiencies in need of remedy at Ogoja. It was the ambition and scale of the plans which drew Money's objection, fearing that government would be forced to over-commit to the scheme, following the tendency among missionary leprosy relief 'to unrestricted expansion resulting in demand for Government or Native Administration financial support as an alternative to.'[24]

The attitude of the RCM, whose leprosy work it was felt should be placed under the direct observation of the Ogoja provincial administration, and be subject to the periodic technical inspection of the Senior Leprosy Officer, was contrasted to that of Dr. Hastings of the Church of Scotland Mission, who, in spite of the offer of funds, claimed to be unable to reconcile any further expansion of leprosy services with the maintenance of a sound basis for the work.[25] With regard to the policing felt proper to RCM plans for the expansion of leprosy control and medical facilities, it was noted that the provincial administration should oversee 'the acquisition of sites for [clinics] and segregation villages and the limitation of

21 ibid., paragraph 8.
22 Ogoja Convent Files - Copy of letter from Dr. J. Barnes [to the Central Leprosy Unit] dated 23rd May 1947. This letter mentions that the recommendations of Money's July 1946 report '[lose] all meaning', not being sent to the RCM Ogoja leprosy scheme until May 1947.
23 NAE, OGPROF 2/1/1790, p. 600. Letter from Dr. J. Barnes to the Senior Leprosy Officer, Nigeria Leprosy Service, dated 9th September 1946.
24 NAE, OGPROF 2/1/1790, pp. 598-99. Letter from T.D.F. Money to the Secretary, Eastern Provinces, dated 27th September 1946.
25 ibid.

these to [serve] the population under the Native Authority which provided [the] site.'[26] In this way, the administrative principles of British rule in Nigeria were to be preserved in Ogoja.

Dr. Feeney, deputising as superintendent of the Ogoja Leprosy Scheme in early 1947, linked the shortcomings in the administration of the scheme to unsatisfactory relations with BELRA. In principle, relations between the organisations were strengthening, and were underpinned by the vote of a BELRA grant towards the Ogoja scheme. However, Feeney felt that the various obligations deriving from these improving relations were not been honoured with sufficient attention on the part of BELRA.

Citing Ernest Muir's failure to notify either Feeney or Barnes of a meeting in Enugu between Muir and other Eastern Provinces leprologists, Feeney outlined two particular points of contention regarding the local effects in Ogoja of current leprosy control policy. In the first place, the inadequate supply of hydnocarpus oil was held responsible for the desertion of leprosy villages by patients. Feeney pointed to an unanswered supplementary requisition made to the Senior Leprosy Officer in this respect, noting scornfully the advice that the number of admissions should be limited - this in an area where 'the total number under treatment is only 1,500 in an area whose population is over half a million and where the incidence of leprosy is probably 40 per mille.'[27]

Furthermore, deploring the inadequate transport situation in Ogoja, where the leprosy workers relied on bicycles and 'native lorry' to make tours, Feeney called for money earmarked for the purchase of a vehicle, or for the vehicle itself, to be made available to the scheme.[28] From an Ogoja perspective, the vagaries of medical supplies and of the transport situation seemed to be symptoms of a systematic official oversight, emphasised by consultative failures, information deficits, and prescriptive and cut-price policies. In actuality, the perceived problems in Ogoja were but one facet of broader organisational

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26 ibid. There is some damage to the edge of the page containing this section of the letter.

27 Ogoja Convent Files - Letter from P. Feeney, Superintendent, Ogoja Leprosy Centre, to Ernest Muir, dated 10th January 1947. This approximates to 20,000 leprosy sufferers province-wide, indicating a coverage of 7.5% by the RCM Scheme.

28 ibid.

difficulties in leprosy control in Nigeria amid the wholesale reorganisations of the immediate post-war period.[29]

Some indication of the administrative confusion resulting from the proliferation of development schemes in the late 1940s was given by the Resident in Ogoja Province, writing to ascertain whether Native Administration and government grants would be payable to the RCM in advance of a more favourable report from Money. Unsure, in late January 1947, whether the 'general slackness' reported the previous June had been remedied by the mission, the Resident was also unable to trace whether the mission had been made aware of the contents of the report.[30] This document was further endorsed by a note enquiring whether certain BELRA monies were to be disbursed.[31] Little more is heard on this matter until late April, when the acting Secretary for the Eastern Provinces wrote to P.M. Riley, the new Resident for Ogoja Province, citing the judgement of Dr. Anderson, the acting Senior Leprosy Officer on RCM Ogoja leprosy work. Quoting Anderson, the letter stated that

> If Dr. Money did not take up the matter of faulty technique etc. with the RCM Ogoja, presumably he had some reasons for not doing so, as he had ample time before proceeding on leave,[32]

continuing to note that since grants for 1946-47 had already been paid, the matter ought not be taken up with the mission at the time of writing. Anderson added that Money's attention to the matter might be required to satisfy conditions for the payment of the following year's BELRA grants.[33]

The opportunity to respond to Money's report was finally taken by Barnes in May 1947,[34] a

[29] Falola (1996), and P.N.C. Okigbo, *National Development Planning in Nigeria, 1900-92,* (London, 1989) describe the *ad hoc* application of planning 'principles' to welfare policy in late colonial Nigeria which resulted in a proliferation of vested interests in defining and administering development, and a profusion of competing bodies for a fixed amount of government money.

[30] NAE, OGPROF 2/1/2861, p. 106. Letter from the Resident, Ogoja Province to the Secretary, Eastern Provinces, dated 29th January 1947.

[31] NAE, OGPROF 2/1/2861, p. 107(a). Telegram from the Resident, Ogoja Province to the Secretary, Eastern Provinces, dated 31st January 1947. This telegram notes that the mission 'have so far received in current year £300 from [the Native Administrations] and £435 from BELRA and ask if balance of £435 from BELRA will be forthcoming before the end of March also capital grant of £1020'.

[32] NAE, OGPROF 2/1/2861, p. 132. Letter from the Acting Secretary, Eastern Provinces to P.M. Riley, Resident, Ogoja Province, dated 26th April 1947.

[33] ibid.

[34] Ogoja Convent Files. Copy of letter dated 23rd May 1947. The sender's address is listed as Ogoja Leper Settlement, while the context indicates that Barnes is the author - reference is made to the authorship of the original plans for the Ogoja scheme. The reference CLU 5/E1 at the head of the letter indicates that its

full year after Money's original series of visits to the Ogoja sites. While conceding the essential truth of the report, Barnes deemed it necessary to take into account the relative youth of the leprosy scheme, and the constraints imposed by shortages accompanying the late wartime and immediate post-war period, writing 'that we are still creeping when the report demands that we not only walk but run.'[35] Barnes countered the contention that the Ogoja scheme was expanding too rapidly with the remark that not only was it difficult on the one hand to 'refuse to do anything for clans where leprosy was rife', but that in any case a reply to the Provincial Leprosy Board issued in advance of Money's report indicated that the RCM had not intended opening any new villages at that point. Wryly, Barnes added that the report's recommendation in favour of consolidation over expansion had become meaningless in view of the year elapsing between its production and its receipt by the mission.[36]

Though admitting the outline of the report, Barnes found much to contend with in the detail. Taking exception to the 'quantity but not quality' judgement reached by Money, which Barnes saw as a 'glib cliché', he interpreted the rapid growth of the preventive, clan-based scheme he had designed as a testament to its salience in the context of Ogoja, and as a concrete rejoinder to 'self-satisfied'[37] policies of centralisation. He took the comments on treatment, dosage and housing as reflecting matters of opinion, adding that the square house was more easily subdivided into rooms, if the need arose. Barnes also pointed out that not only did he use the yellow record cards provided by the government, and showed these to Money, but that the lay-out plans for the divisional centre, the absence of which drew comment in the report, had not in fact been requested. A list of three Sisters and eight licensed injectors was provided, and Barnes commented that he had only operated on five open abcesses from injections since the beginning of the year.

Regarding the issue of sanitation, Barnes noted that he considered the construction of latrines as secondary to that of housing, and that the shallow trench latrines in place, though not

intended recipient is at the Central Leprosy Unit, in Uzuakoli.

35 ibid.

36 ibid.

37 ibid.

ideal, '[defended] man from the just accusation of the plant Kingdom of being a pure parasite', adding that 'in our enthusiasm for sanitation let us not lose sight of sanity'.[38] He also drew attention to a properly constructed latrine at Abakaliki which had been in place at the time of Money's visit. In further contradiction to the report, Barnes firmly held that admissions were restricted to members of the clan holding the land granted, except in the case of the divisional centre, where strangers were not allowed to farm.

In any event, by the time it came to act on Money's report, he had been replaced as Senior Leprosy Officer, leading McGettrick to comment to Martin in a letter of June 1947 that 'Money... who was not at all favourable to [the RCM] or to any Mission has resigned, and for that thank God as he was very obstructing in his tactics'.[39] The same letter draws attention to Muir's adverse report on leprosy colonies handed over to Government, a report which favours mission retention of leprosy work. Within a short period of time, the question as to who was best suited to provide leprosy services would dwindle in significance, as the whole basis of leprosy treatment was revolutionised by the application of new chemotherapeutic means with the promise of cure and discharge of great numbers of leprosy patients worldwide.

Chemotherapy and clinical trials in leprosy: situating Ogoja in a global research context

The quest for effective chemotherapeutic agents, which had seized medical specialists in the early part of the twentieth century, extended to tuberculosis and leprosy rather late in the day. Mark Harrison and Michael Worboys note that:

> Before 1940, tropical medical specialists and the colonial medical services paid little attention to [tuberculosis], being preoccupied with parasitic, vector-borne diseases and their control.[40]

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[38] ibid.
[39] MMM archives - 1/Dio/8/40 Letter from McGettrick to Mother Mary Martin dated 8th June 1947.
[40] M. Harrison and M. Worboys, 'A disease of civilisation: tuberculosis in Britain, Africa and India, 1900-39', in L. Marks and M. Worboys, eds., *Migrants, Minorities and Health: Historical and Contemporary Studies*, (London: Routledge, 1997), p. 93.

John Iliffe notes the growing scepticism which greeted the use of chaulmoogra oil in leprosy treatment by the late 1940s, though Eric Silla contends that persistent conservatism prolonged its use in places, even as it came to be superseded by new drugs.[41] However, the relative weakness of the therapeutic arsenal of pre-antibiotic and pre-sulphone mission medicine, characterised in Terence Ranger's account of pre-1945 Tanzania by alternately spectacular and hopeless medical missionary responses to disease outbreaks and to new cures,[42] generally yielded to a more resolute and self-possessed clinical optimism in the years following World War Two.

The cyclical mutedness and pessimism of mission medicine in its pre-war vintage,[43] powerless to substantiate its spectacle and realise its redemptive aims, seemed itself disposed to an almost transcendent transformation in the fierce crucible of co-operation and innovation of the late 1940s. This led to a decisive shift in the character of mission medicine, presided over in Ogoja by Joe Barnes. Both a progenitor of and an accompaniment to the therapeutic shift which shaped the new missionary medical accommodation can be discerned in examining Barnes' assembly, amid straitened circumstances, of a series of interventionist strategies of patient organisation and of a diverse pharmacopoeia.

Some indications of the tensions implicit in this shift can be discerned from Barnes' early account of the future of leprosy control, published in the MMM jubilee publication The First Decade. This modest assessment of the promise of effective treatment, pre-dating a more widespread acceptance of the efficacy of the sulphone drugs in leprosy, opens with the stark confession that 'I suppose there are many lepers, there have been many lepers and there will always be lepers.'[44] Cautioning against the search for a panacea, Barnes counsels an

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[41] J. Iliffe, *The African Poor*, (Cambridge, 1987), p. 225; E. Silla, *People Are Not The Same: Leprosy and Identity in Twentieth-Century Mali*, (Oxford, 1998), p. 109.

[42] T. Ranger, 'Godly medicine: the ambiguities of medical mission in southeastern Tanzania, 1900-1945', in S. Feierman and J.M. Janzen, eds., *The Social Basis of Health and Healing in Africa*, (Berkeley: University of California Press, 1992), pp. 263-70 contrasts missionary experiences with yaws and measles - successive 'pilgrimages' for treatment seemed to offer inconclusively successful cures for yaws, while measles underlined the shortcomings of medical therapies and supply lines in rural colonial settings during the interwar period.

[43] See chapter three.

[44] J. Barnes, 'The outlook for the leper of the future' in *The First Decade: Ten Years Work of the Medical Missionaries of Mary, 1937-1947*, (Dublin: At the Sign of the Three Candles, 1948), p. 53.

assiduous, catholic approach to treating leprosy with all means at the disposal of the doctor and his staff, reminding the reader of the problematic ethical concerns raised by the failure of scientists to inoculate any experimental animal with leprosy.[45] It was pointed out that any of the new treatments proposed for leprosy would have to be assessed for efficiency on human trial subjects.

In the course of a philosophical exploration of the ethics of human experimentation, Paul McNeill writes of

> [coming] to see human experimentation itself… as a political process… as a balancing of different priorities in the community as a whole. Recognising the political dimension makes it apparent that the appropriate mechanism for the resolution of ethical issues in experimentation will also involve political considerations.[46]

Citing a number of infamous examples of patently unethical research conduct, he notes that 'the important issue in all of [these] cases was the lack of therapeutic intent and a callous disregard for the welfare of the subject'.[47]

Since McNeill's express purpose is to examine and specify underpinnings for national ethics committees, it is not surprising that his appreciation of the historical context of human clinical experiment is decidedly instrumental and self-limiting in nature. What is perhaps more surprising is that the historiography of the clinical trial was still so weak and unsatisfying at the time McNeill was writing, consisting mainly of lists of successive epistemologically significant clinical trials. Since this time, Susan Lederer has identified the problems inherent in creating a history of clinical experiment, following Gert Brieger in pointing out that

> going beyond [collating] a mere catalogue of human experiments requires knowledge not only of medical practice and medical science but of political, cultural, economic, and philosophical assumptions and conditions in society.[48]

Harry Marks makes some interesting remarks on productive new trends in the sociology of science seeking to analyse the personal relations and institutional politics which underpinned

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[45] ibid., pp. 55-57.
[46] P.M. McNeill, *The Ethics and Politics of Human Experimentation*, (Cambridge, 1993), p. *xi*.
[47] McNeill (1993), p. 19.
[48] S.E. Lederer, *Subjected to Science: Human Experimentation in America Before the Second World War*, Baltimore, (1995), p. 183.

successful clinical experimentation using the same methods applied to failed projects, generating a historiographically useful agnosticism towards experimental outcomes.[49] This novel sociology equips the scholar with a means of unpicking teleologies in the history of clinical experimentation.

The strengths of this literature lie in considerations of the extremes of human experimentation encountered in the context of war, and especially of World War Two, which, as well as unleashing some of the most appalling examples of human experimentation for ostensibly clinical purposes, is proposed as somewhat of a watershed in the development of scientific experimental method in clinical research. Certainly, the concurrence of rapid pharmacological advance, increased and directed national and global funding, and the development of research programmes in the immediate post-war years would seem to validate this proposition.

It is difficult to discern the extent to which the explanatory force of this proposition is merely an artefact of an under-elaborated historiography. A focus on the spectacular, the morally reprobate and reprehensible, both in wartime and in commentary on colonial excesses, would seem to deform an understanding of the elaboration of the clinical in the context of colonialism, decolonisation and emerging development ideologies. Likewise, an emphasis on trials characterised by successful outcome seems to misrepresent the practice of, and interaction between clinical and laboratory medicine in the post-1945 era. In the light of occurrences in Ogoja, and in relation to the literature on clinical trials, it is important to point out that the assessment of ostensibly marginal and ill-administered trials sets conceptual and historical parameters for understanding the development of the clinical trial in medicine.

By the 1950s, contemporary meditations on the use of clinical trials in medicine readily conceded the persistent shortcomings of the trial process, casting it as a strategic interface between developments in the science of organic chemistry and the practice of clinical medicine. The nineteenth and twentieth century development of more precise disease

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[49] H.M. Marks, *The Progress of Experiment: Science and Therapeutic Reform in the United States, 1900-1990*, Cambridge, (1997), ch. 1, cites Latour and Knorr-Cetina as progenitors of this approach.

aetiologies, and the consequently improved consistency of clinical observation, had stabilised a process of therapeutic advance which enabled researchers to build on one another's results with more confidence than hitherto. And yet, the extent to which the recognition of therapeutic problems could be matched by the institutional conditions for a successful clinical trial continued to pose problems for researchers, further compounded in the circumstances of colonial government and missionary health services.

In a contemporary overview, published in 1959, noting that the status of the clinical therapeutic trial as a scientific experiment was, at best, 'modest',[50] J.P. Bull details the tendencies which typically corrupted the scientific validity of such trials. It was often difficult to agree standard criteria for effectiveness of a new drug, though these had begun to become more stringent as the twentieth century had progressed.[51] Bull notes the inconclusiveness of a trial of emetine in amoebic infections, made in the early twentieth century by Rogers on three patients, which foundered not only on the small sample size, but on the vagaries of the clinical course of the infections and the absence of a long follow up.[52] Vagaries resulting from incomplete distinction between diseases or sets of symptoms, or from variations of presentation along the course of an illness, together with the institutional constraints on controlling and monitoring patients, greatly qualified the utility of many clinical trials. However, the publication of results of even the most inconclusive and partial of trials was encouraged; in the case of Rogers' trial, promising results, however 'unconvincing',[53] prompted other researchers to work to confirm the results.

The charge of ethical duty, assumed by the clinician, also factored into decisions as to the status of the control group in clinical trials. In cases where experienced clinical observation underpinned clear diagnosis and understanding of the course of the illness, cautious interpretation of the results was assumed to be a valid stand-in for the lack of a formal

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[50] J.P. Bull, 'The historical development of clinical therapeutic trials', in *Journal of Chronic Diseases*, 10, 3 (1959), p. 242.
[51] Bull (1959), p. 236.
[52] ibid.
[53] ibid.

control group,[54] giving interpretive latitude to the role of clinical judgement in the construction of the trial. This process also foregrounded the spectacular effects of new drugs, as instanced by the case of late 1930s sulphonamide trials in meningococcal meningitis, carried out by Banks, where:

> No formal controls were arranged, comparisons being implied with the previously uniformly high mortality in this clearly defined disease and with the intermediate results in the first inadequately treated cases.[55]

The resultant valorisation of chemotherapeutic approaches paradoxically short-circuited the application of clinical judgement, effectively ritualising the recourse to powerful new families of drugs such as the sulphonamides and penicillin.

This process was neither straightforward nor uncontested. As a result of the categorical flux induced by the uncertain and constantly renegotiated status of the clinical trial, wide scope for the framing and reporting of clinical research persisted, as did a spirited and intense contestation of the validity of results. The consequent unease is keenly depicted in Barnes' report on the status of leprosy research in The First Decade. Noting that chaulmoogra oil was 'not a radical cure for Leprosy',[56] he commented on the humiliation induced by the reliance of leprologists on substances found effective in the treatment of tuberculosis, according only to the principle of bacteriological analogy.[57] In 1947, Barnes was evidently of the opinion, given the experimental shortcomings resulting from the inability to test leprosy drugs in animals, that the preventive functions of the isolation village, the assiduous attention to the isolation of infectious cases and the non-dramatic cure of early cases using chaulmoogra oil, and the elaboration of the institutional leprosy scheme as a form of curative method in itself, were more scientific in intent than chemotherapeutic trials prompted by guesswork and conducted by trial and error.[58]

Perhaps due to the increasing weight of evidence that certain sulphone drugs might be useful

[54] Bull (1959), p. 237.
[55] Bull (1959), p. 239.
[56] Barnes (1948), p. 54. Italics and capitalisation in the original.
[57] Barnes (1948), p. 56.
[58] Barnes (1948), p. 57.

in controlling leprotic reactions, new drugs were being tried out in Ogoja by mid-1948.[59] Barnes, studying dermatology in Leeds and Paris in 1948-49,[60] wrote to the MMMs in Drogheda with information of Sr.-Dr. Visitation Chambers' encouraging results in Ogoja in his absence[61] with calciferol, a preparation of calcium and vitamin D effective in tuberculosis of the skin.[62] Experimental work was also being carried out with Promin.[63] Barnes' presence in Britain and in Ireland at this stage helped to increase the profile of the RCM Ogoja leprosy scheme, giving the opportunity of complementing selected showings of Visitation with lectures by Barnes,[64] affording him the chance to meet with Gordon Ryrie, the Medical Secretary for BELRA, to propose making a film on leprosy and gaining research support for Ogoja.

Barnes' stay in Paris enabled him 'to study the advances in the treatment of leprosy and compare his own findings with those of other experts.'[65] The state of knowledge regarding the disease and its treatment had been set out at the International Leprosy Congress in Havana, Cuba in April 1948, attended by T.F. Davey of the Nigeria Leprosy Service. The less haemotoxic derivatives of diaminodiphenylsulphone,[66] namely promin, which was being examined in Ogoja, diasone and sulphetrone, were recommended for their value in attenuating lepromatous leprosy and addressing eye lesions. Rapid clinical improvement was followed by much slower bacteriological improvement, though marked numbers of patients exhibited sensitivity to the drugs. Minimum therapeutic requirements for clinical tests were

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[59] MMM archives - 1/Fou/4(n.1)/8. Cover letter dated 12th May 1948 from Sr. M. Aloysius Connolly (London) to the MMM Sisters, Ogoja.
[60] ibid., and author's interview with Joe and Betty Barnes, 27th March 2000.
[61] MMM archives - Folder entitled 'Dr. Barnes - leprosy- bacteriology'. Letter dated 9th March [1949] from Dr. J. Barnes in London.
[62] Barnes (1948), p. 56.
[63] Ogoja Convent Files - Annual report 1948 - Leprosy Treatment Centre: Roman Catholic Leper Settlement, Ogoja.
[64] MMM archives - Folder entitled 'Dr. Barnes - leprosy- bacteriology'. Letter dated 15th January 1949 from Dr. J. Barnes in Leeds.
[65] *The Medical Missionary of Mary*, 10,8 (1949), pp. 3-4.
[66] The drug which is now commonly referred to as dapsone was variously referred to as diaminodiphenylsulphone, DADPS and DDS in the late 1940s. Its haemotoxicity was seen as a major barrier to its utility as a chemotherapeutic agent. Sulphetrone, promin and diasone were expensive derivative sulphones used in preference to the much cheaper dapsone in many settings - research work at Uzuakoli eventually showed that the derivative drugs were metabolised as dapsone in the liver, leading to attempts to balance the dose of dapsone with the required concentration in the blood determined from its less irritant derivatives.

proposed, centring on evidence of antibacterial action, absence of toxic effects or irreversible physiological changes, freedom from undue discomfort, and visible clinical and bacteriological evidence of suppression or regression of leprosy within twelve months.[67]

While such research raised hopes and promised rapid advances in leprosy chemotherapy, the pronouncements of the Congress on classification of leprosy disappointed Nigerian representatives. Drawing on the Pan-American classification system agreed in Rio de Janeiro in 1946, which reconciled previous systems based on heterogeneous combinations of clinico-anatomical, histopathological and immunological factors into a single continuum 'believed to be based on a biologic interpretation of the clinical facts',[68] the Classification Committee of the Congress proposed a polar opposition of recognisably lepromatous (malignant) and tuberculoid (benign) leprosy, each internally differentiated according to measure of severity, bridged by a class of indeterminate (undifferentiated) cases. The clinical subdivision would be organised according to class, degree of severity, manner of evolution, localisation (on the body), morphology and clinical form, thus marrying classical descriptions of symptoms with prescriptive aids to therapeutic options. Davey objected to the confusing subdivisions, noting that in Nigeria 'the indeterminate group is not merely a group but covers a considerable proportion of all cases, and embraces types not described in the proposals.'[69] The notion that tuberculoid and indeterminate cases were non-infectious was vigorously contested by Davey, and proved a controversial issue in Nigerian leprosy research over the following years, especially in the light of the Congress' recommendation that these cases should not be included in the evaluation of chemotherapeutic trial results.[70]

For Barnes' part, his visit of 1948-49, during which he married Elizabeth Allday,[71] an English doctor working in the new British National Health Service, had also introduced him to the work of Vincent Barry on the chemotherapy of tuberculosis.[72] Barnes and his wife travelled

[67] International Leprosy Congress, *Memoria del V Congreso Internacional de la Lepra : celebrado en La Habana, Cuba del 3 al 11 de Abril de 1948 / organizado por el Gobierno de la República de Cuba con la colaboración de la Asociación Internacional de la Lepra*, (Havana: Editorial Cenit, 1949), pp. 68-69.
[68] International Leprosy Congress (1949), p. 73.
[69] International Leprosy Congress (1949), p. 75.
[70] International Leprosy Congress (1949), p. 69.
[71] ibid.
[72] Author's interview with Joe and Betty Barnes, 27th March 2000.

to Ogoja in July 1949, and set about trialling new chemotherapeutic agents in the leprosy settlements there. Joseph Barnes was unconvinced by the use of dapsone in treating leprosy, as he objected to what he saw as its excess toxicity in the doses administered in the late 1940s. Prior to its standardisation, and its adoption as the chemotherapeutic agent of choice by the Nigerian Leprosy Service, Barnes obtained sanction to use sulphetrone, another sulphone derivative, in its place. 1948 had seen the first full year of research at the BELRA Leprosy Research Unit at Uzuakoli, with promising new results reported in the administration of sulphetrone to patients with tuberculoid leprosy, held in this account to constitute the majority of Nigerian cases.[73] It was with sulphetrone, a more expensive but ostensibly less toxic derivative of dapsone, that Barnes and Allday began to treat patients in Ogoja.

Sulphetrone had the advantage of being freely soluble;[74] Barnes and Allday administered it by subcutaneous injection,[75] mirroring the process employed in previous chaulmoogra oil therapy and side-stepping the predicted impact on attendance associated with oral administration of tablets. Alongside sulphetrone, administered to 657 patients over a period of two years, Barnes and Allday trialled dapsone for toxicity on 153 cases, and administered thiosemicarbazone to ten patients. These three drugs were the most significant in terms of worldwide research in leprosy chemotherapy at the time, and the results produced at Ogoja could be interpreted as contributing to attempts to refine and standardise the administration of these drugs.

While Barnes' early agnosticism with regard to the efficacy of chemotherapeutic approaches to leprosy had not precluded experimental approaches to treatment of the disease under the auspices of the Roman Catholic Mission in Ogoja, his period of study in Europe in 1948-49 had underlined to him the potential of new approaches then being examined by clinical leprologists in a wide variety of experimental contexts in India, Britain and Africa. Thus, the sceptical approach notable in his contribution to the MMM publication *The first decade: ten*

73 *British Empire Leprosy Relief Association, Annual report,* (1948), pp. 5-6.
74 International Leprosy Congress (1949), p. 67.
75 J. Barnes, 'Diaminodiphenylsulphone in leprosy' in *The Lancet*, (Sept. 29th, 1951), p. 595.

years work of the Medical Missionaries of Mary, 1937-1947, was balanced with a willingness to use novel treatments in a limited fashion. This is demonstrated in correspondence with Mother Mary Martin, where Barnes notes the success of Sr. Visitation Chambers with the use of calciferol (vitamin D) in Ogoja, pointing out that her results would be of interest to 'the Medical School... they are looking forward keenly to it'[76]

In the case of the compound known as B.283, however, the experimental work carried out in Ogoja was both novel and somewhat exotic. The initial trial begun in January 1951 was with ten patients, and, consistent with the recommendations of the Havana Congress, all ten had been diagnosed with lepromatous leprosy.[77] No reports were yet available on the success of the drug in treatment of tuberculosis in Ireland, although concurrent human trials were in progress. Specific note is made of the impossibility of employing an untreated control group, given that 'our patients would not remain isolated without the inducement of treatment'.[78] Alongside the trial in lepromatous leprosy, a report on which was published in the *Irish Journal of Medical Science*, ten patients with tuberculoid leprosy were also treated with B.283.[79] This dual trial, in contradiction to the recommendations of the Havana Congress, reflected new research trends occurring in Eastern Nigeria at the time, where the predominance of tuberculoid and 'indeterminate' over lepromatous leprosy[80] rendered internationally conceived and agreed experimental strictures unworthy of application.

In July of 1951, a four day colloquium on the chemotherapy of tuberculosis was held in Dublin, under the sponsorship of the Medical Research Council of Ireland. The Council, in conjunction with the *Oireachtas,*[81] was funding extensive research into tuberculosis drugs,

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76 MMM Archives – Drogheda. Typed copy of letter from Martin to Barnes in England, dated 14th March, 1949. The letter is in an unindexed folder entitled *Dr. Barnes – Leprosy – Bacteriology.* This is the only indication I have seen of an assessment of calciferol in Ogoja; it is unclear from the context which medical school is in question – given the association of the MMMs in Dublin with University College, this is most likely the institution referred to.

77 E.J. Allday and J. Barnes, 'Treatment of leprosy with B.283', (1952), p. 422.

78 ibid.

79 Ogoja Convent Files. Letter dated 29th September 1951 from J. Barnes (Dublin) to D. Freeman (Ogoja) mentions the two sets of cases.

80 International Leprosy Congress (1949), p. 75.

81 *Oireachtas* is the collective name for the Irish Houses of Parliament, *An Dáil* (elected lower house) and *An Seanad* (predominantly appointed upper house). The formation of the latter, by De Valera's 1937 constitution, reflects a predominant Catholic fascination with vocational social organisation.

carried out by a team under Vincent Barry at Trinity College, Dublin. A summary of the proceedings,[82] noting the international character of both the speakers and the attendance, and the patronage of the *Taoiseach,*[83] Éamon de Valera, and the Irish President, Seán T. O'Kelly, was published in *Nature*. In the second of seven sessions Barry presented a report on the results of empirical research by the Irish team on the synthesis of drugs of potential value in tuberculosis and leprosy, including a series of long branched hydroxyamines, and a series of phenazine dyes derived from the lichen product, diploicin.

Prior to and during World War Two, Barry had worked with a research team headed by Professors H. Ryan and T.J. Nolan, of the University College, Dublin Chemistry Department, who, along with Joseph Algar, had determined the structure of diploicin, a halogenated diphenyl ether, then the only known naturally-occurring chlorine containing compound.[84] While the tenacious exploratory work of Barry and his team would eventually lead to the synthesis of clofazimine, currently one of the most important compounds in the treatment of leprosy and its inflammatory complications,[85] later considerations of the development of clofazimine (which constitute the primary source of historical reflection on the work of Barry's team[86]) generally fail to acknowledge the importance to Barry's project of his early reflections on treatments used in leprosy. What has usually been represented as a project on the chemotherapy of tuberculosis, only incidentally and fortuitously germane to leprosy, was from its inception influenced by analysis of leprosy chemotherapeutic agents.

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82 V.C. Barry, 'Chemotherapy of tuberculosis', in *Nature*, vol. 168, no. 4274 (29th Sep., 1951), pp. 539-41.

83 *Taoiseach* is the official designation for the Irish prime minister.

84 V.C. Barry, 'Boyle medal lecture: synthetic phenazine derivatives and mycobacterial disease: a twenty year investigation', in *Scientific Proceedings of the Royal Dublin Society*, Series A, 3, 16 (1969), p. 154-55, and D. Twomey, 'An Irish solution for a non-Irish problem', in *Irish Chemical News*, (Spring 1986), p. 10. I thank A.C. McDougall and Jo Robertson for sharing the Twomey source with me.

85 McDougall and Yuasa, *A New Atlas of leprosy*, (2000), pp. 4-5, and V. Pannikar, *The Return of Thalidomide: New Uses and Renewed Concerns*, available at the WHO URL: www.who.int/lep/TAG/Thal.doc – last consulted, 2 August 2004.

86 R. Darcy and unidentified others, 'Obituaries: Sean O'Sullivan: scientist who helped discover new drug to treat leprosy', in *Irish Times*, (October 5th, 2002), p. 14, exemplifies the pre-eminence of clofazimine in assessing the careers of scientists involved in Barry's team. Stanley Browne, a key player in the standardisation of clofazimine for the treatment of leprosy, notes in 'Obituary: Dr. Vincent C. Barry', in *Leprosy Review*, 47 (1976), p. 64, that 'Barry “came into leprosy” with the synthesis of compound B283, which was shown to be active against the disease in a small series of cases in Eastern Nigeria.' I have been able to establish Raphael Darcy's co-authorship of the first source thanks to the generosity of A.C. McDougall, who shared with me materials sent to him by Dr. Darcy.

This can be seen from Barry's 1946 presidential address to the Irish Chemical Association, cited in the opening quotation to this chapter, which notes the potential of branched-chain fatty acids in treating tuberculosis. Two separate discoveries are cited as underlining this potential: firstly, that branched-chain fatty acids were present in the lipoid fraction of tuberculoid and other acid-fast bacilli, and secondly, that chaulmoogric and hydnocarpic acids, isolated from chaulmoogra oil and held to have active therapeutic effects in leprosy (a claim which has been latterly disputed, as pointed out by John Iliffe[87]), had also recently been shown to belong to this category of acid, and to be weakly inhibitory of the growth of the tubercule bacillus. Intuiting that this inhibitory effect might be related to a disruption of the metabolic processes and chemical composition of the bacillus, it was decided to empirically evaluate a series of modified branched-chain fatty acids for anti-tubercular activity.

Without a dedicated laboratory at this stage, Barry worked in Ryan and Nolan's old laboratory, and decided to examine some of the byproducts of their previous work with diploicin and related diphenyl ethers, on the basis that a sodium salt of a carboxylic acid of diploicin had inhibited tubercule growth in horse flesh broth.[88] One unsuccessful compound, rather than being discarded, was left in storage for a number of months,[89] and demonstrated striking anti-tubercular properties upon its retrieval. It had also changed colour from near colourless to dark red, and it was surmised that the anti-tubercular activity was related to the oxidation product which had generated the pigmentation. A series of these phenazine dyes were subsequently examined by Barry and his team.

Among the phenazine dyes, one in particular maintained its effectiveness as an anti-tubercular agent both in serum and in mouse and guinea pig tuberculosis, and was as such one of the few investigated compounds to retain its activity beyond the *in vitro* stage.[90] This

[87] Iliffe, (1987), pp. 214-29.

[88] Barry, 'Boyle medal lecture', (1969), p. 154.

[89] Twomey, 'An Irish solution' (1986), p. 11, likens this inadvertent process to Alexander Fleming's serendipitous results with penicillin.

[90] V.C. Barry, 'An organic chemists' approach to the chemotherapy of tuberculosis', in *Irish Journal of Medical Science*, Sixth series, No. 310 (Oct. 1951), p. 453. Intriguingly, of the compounds listed by Barry which retained anti-tubercular activity in the guinea pig, the three which had some measure of success in treatment of leprosy – dapsone (diaminodiphenylsulphone), Conteben (thiosemicarbazone), and B.283 (2-anilino-3-imino-5-phenyl-phenazine) – were noted as having 'one property in common: they all contain a basic nitrogenous group', while seemingly sharing no other obvious relationship.

compound, 2-anilino-3-imino-5-phenyl-phenazine,[91] known by Barry's team as B.283, was subject to encouraging animal trials (in abeyance at the time of the Dublin colloquium),[92] and was later applied in ongoing clinical assessments on human subjects in the Meath Hospital[93] (urogenital tuberculosis) and Rialto Chest Hospital (pulmonary tuberculosis) in Dublin. Barnes had encountered this research while in Dublin between tours in Ogoja, and discussed the possibilities of applying the compound to the treatment of leprosy, with the result that Barry was able to demonstrate some success in the treatment both of tuberculosis and of leprosy by the time of the Dublin colloquium, thanks in part to a series of photographs exhibited by Barnes, whose trial of B.283 in Nigeria was yielding promising interim results.[94] From the point of view of the scientific team based around Barry, Barnes' desire to trial B.283 in the treatment of lepromatous leprosy constituted promise of 'fresh clues to guide synthetic work', and it was noted that 'the activity in vivo of these basic fatty substances is of especial interest, as it provides some justification for the long preoccupation of of workers in the field with compounds of a fatty character'.[95] This indicated the varieties of response to chemotherapeutic developments in tuberculosis at the Dublin colloquium: the atmosphere of polite patience on the part of the clinicians awaiting the desired drugs, of the bacteriologists' quiet confidence in their methods, and of the fruitful optimism of the biologists was tempered only by the melancholy of the chemists, condemned to an empirical rigmarole which they deemed ill-suited to the ambitions of their science.[96]

As a result of this remarkable convergence of chemotherapeutic approaches to tuberculosis

[91] Barry, 'Boyle medal lecture', (1969), p. 155 cites the late nineteenth century work of Schöpff, Fischer and Dischinger on the same compound, which was given the name anilinoposafrinine, by which name it is also ited in scientific literature.

[92] V.C. Barry, 'An organic chemists' approach to the chemotherapy of tuberculosis', in *Irish Journal of Medical Science*, Sixth series, No. 310 (Oct. 1951), p. 470.

[93] T.J.D. Lane, 'Chemotherapy in urinary tuberculosis', in *Irish Journal of Medical Science*, (1951), pp. 393-405.

[94] ibid., and Barry, 'Chemotherapy of tuberculosis', p. 540.

[95] Barry, 'An organic chemists' approach...' (1951), p. 473. Twomey, 'An Irish solution', (1996), p. 10, comments on the unwitting and reluctant participation of the Irish researchers in a then-fashionable field in biochemical enquiry!

[96] Barry, 'Chemotherapy of tuberculosis', p. 540-41. Barry's discussion of the derivation of drugs by empirical rather than rational means is commended for its 'honesty', indicating a measure of methodological disappointment at the progress of his team's work, despite the 'general agreement that no chemotherapeutic agent has yet been discovered by a completely rational approach'.

and leprosy,[97] and the particular conjuncture in the history of Irish science represented by Barry's work, Barnes was able to present the interim results of this clinical trial at a major international colloquium. Joe and Betty Barnes had recently returned from their final tour in Ogoja, where Joe had founded the provincial leprosy service only six years previously, making it all the more remarkable that a clinical trial conducted in Ogoja could elicit such hope and attract such attention. Indeed, Barnes made a number of other high profile contributions to the colloquium - notably, following a lecture by Gerhard Domagk on the use of thiosemicarbazone,[98] which Domagk himself had developed, in tuberculosis and leprosy, Barnes commented that the drug had proved much more useful in limiting tuberculoid than lepromatous leprosy, adding texture to the exploratory worked carried out by Gordon Ryrie in Britain, and by John Lowe in Nigeria.[99]

An analysis of the clinical management of the first trial of B.283 at Ogoja, transferred from Dr. Barnes to Dr. Denis Freeman midway through the trial period, offers a unique insight into the social, infrastructural, and informational contexts of and constraints upon methods then developing in clinical experimental conduct and procedure. The correspondence between the two men, and between them and the various parties to the broader experimental context of post-1945 pharmacology, is peppered with observations on the conduct of healthcare in Nigeria, Britain and Ireland, on the appropriate equipment and services required to successfully document clinical outcomes related to drug trials, and on the mechanics and expertise evolving around diagnostic procedure, as bacteriology and pharmacology

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[97] E.J. Allday and J. Barnes, 'Treatment of leprosy with B.283', in *Irish Journal of Medical Science*, Sixth series, No. 322 (Oct. 1952), p. 421 remarks that the 'close bacteriological relationship between the two mycobacteria and the good practical results obtained in leprosy with the sulphone and thiosemicarbazone drugs which were originally introduced for the treatment of tuberculosis has led to the practice of assaying in leprosy any drug found to be effective in tuberculosis.' E.J. (Elizabeth) Allday was the maiden name of Betty Barnes, used in this and related publications.

[98] Para-acetamidobenzaldehyde thiosemicarbazone, shortened to thiosemicarbazone, was also referred to as thiacetazone, Conteben, T.B. 1/698, and T.B.l. It was largely superseded in the treatment of tuberculosis by, although continued to be used in combination with, isozianid, also developed by Domagk.

[99] For Barnes' remarks, see Barry, 'Chemotherapy of tuberculosis', p. 541. Barnes' observations, based on the treatment of ten patients with thiosemicarbazone, can be found in J. Barnes, 'Treatment of leprosy with thiosemicarbazone', in *The Lancet*, (Aug. 11th, 1951), p. 268. Ryrie, formerly Medical Secretary of BELRA, gave an account of the treatment of ten patients in Britain in G.A. Ryrie, 'Thiosemicarbazone in the treatment of leprosy', in *The Lancet*, (Aug. 19th, 1950), pp. 286-87. J. Lowe, 'Para-acetamidobenzaldehyde thiosemicarbazone in the treatment of leprosy', in *The Lancet*, (Mar. 1st, 1952), pp. 1012-13, documents a more extensive trial at Uzuakoli, with which Barnes may have been familiar.

converged in the clinical nexus. Scholarly literature on the evolution of experimental methods in biomedicine is largely inattentive to more marginal or less expressly successful trials: in this regard, the Ogoja example offers a worthwhile and telling corrective to dominant historical models of clinical experiment outlined above.

In comparison with other indications of interest in B.283 for the treatment of leprosy, such as the prospective trials at Makogai, Fiji and Sokoto, Northern Nigeria, indicated in Barnes' correspondence,[100] extensive documentation exists in Ogoja of the experimental work carried out there. This is not the case for all compounds examined in Ogoja: indeed, it is the transfer of responsibility from Barnes to Freeman, far from ideal as this was felt to be, which facilitates the examination of the progress of this trial. In contrast, the experience of Barnes, Allday, Chambers, Feeney, and Freeman with drugs such as dapsone, sulphetrone, chloromycetin, calciferol, and myvizone register but little on the archival and published record.

One strand in this correspondence concerns the conceptual and philosophical outlines of the trial process in which the two clinicians were engaged. Much of this material is abstracted from reflection on the practicalities and logistics of carrying out research in such a remote location, and thus provides a sense of the infrastructural demands of laboratory and clinical work in ostensibly marginal colonial settings. Barnes conceded that his interim report on the B.283 trial had been inclined towards optimism, in contrast to the caution which had characterised his first spell in Ogoja, but the ensuing discussion between the two doctors, based on the individual cases, raises significant questions about the adequacy of diagnosis as practised in Ogoja and of the presentation of clinical information to a broader scientific and lay audience.[101]

Robert Cochrane, among the most eminent working leprologists, based by this time in Britain, had visited Freeman in Ogoja, and had queried some of Barnes' diagnoses on which case selection for the B.283 trial was based. Commenting on the resulting disagreements,

[100] Ogoja Convent Files. Letter from Barnes to Freeman, dated [28th] September, 1952.
[101] Ogoja Convent Files. Letter from Barnes to Freeman, dated 5th May, 1952.

Barnes wrote that they may have arisen

> because you had only an abbreviated summary history of the cases and none of the original photographs... from these photoes [sic] and descriptions you may classify for yourself these cases, but it is not likely many will disagree for as you know there is a variety of classifications for leprosy. It must have been difficult for Cochrane who never saw these cases if he had not all the data I have now given you, as well as a missing lepromin reaction and tissue section which from your letter I understand he requires for the complete diagnosis of such cases.[102]

Barnes' queried the accuracy of the term 'atypical', applied to the diagnosis of a presentation of leprosy he had classed as 'pre-lepromatous', noting infiltrations on the nose and ears, giving positive smears, as evidence of the case having crossed a border to lepromatous.

Coupled with diagnostic difficulties were a series of technical issues which obviated the validity of some of the eventual conclusions of the trial. The nearest pathology lab. was in Lagos, and at the time of the jointly-conducted trial on B.283 Barnes and Freeman relied on black and white photography to document their diagnoses. Neither doctor was confident in their documentary abilities with a camera: thus the advice sent by Barnes to Freeman

> 1. white background such as a wall or sheet. 2. Lesions so adjusted to catch the rays of the sun on the slant. 3. three feet distance from lesion to lens. 4. timer 1/100 sec. 5. aperture vary according to lighting – if in doubt – 3 apertures f.5, f.7, f.9 for 3 separate snaps. 6. panchromatic film.[103]

The striking dissociation of disease and symptom from patient, so often noted as a hallmark of laboratory pathology, is very much to the forefront in these technical considerations, nowhere more so than in the characterisation of lens-object distance with regard to the 'lesion'.

Alongside updates on equipment needed in Ogoja and advice on the conduct of the first B.283 trial, Barnes letters from Ireland reported medical and personal news relating to novel chemotherapies and social and professional events in Dublin. Amongst the personal vignettes was included repeated commentary on the doings of Freeman's father, Edward, a prominent Dublin physician, whose pronouncement that 'to learn a technique is easy, what is difficult is judgment of its use' had particularly impressed itself on Barnes.[104] Such comments are a

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[102] ibid.

[103] Ogoja Convent Files. Letter from Barnes to Freeman, dated 2 April 1952.

[104] Ogoja Convent Files. Letter from Barnes to Freeman, dated 14th June, 1952, reporting the impact of his plenary address to the joint British Medical Association/Irish Medical Association meeting in Dublin in 1952 on Freeman's father's growing reputation among Irish physicians.

reminder of the professional and international context in which the somewhat disputed reports on the efficacy of B.283 in leprosy were promulgated. Indeed, the setting for this material is especially complex, as it draws on, and illustrates, an international milieu which throws the Ogoja material into relief. The changing state of knowledge with regard to treating tuberculoid leprosy, signalled in the recommendation of the Havana Congress that clinical trials be carried out on lepromatous cases, impacted on the validity of the results of many trials being carried out in Nigeria in the early 1950s. Freeman's second trial on B.283 in tuberculoid leprosy seems, for instance, to have disappeared without a trace.

Whatever the validity of Barnes' methods and diagnoses – the correspondence quoted above gives an indication only that it was open to dispute – its publication in *The Irish Journal of Medical Science* gave it a currency, and gave the relation of Barry's work on tuberculosis chemotherapy to leprosy a continuing identity, which emerged as vital in the development of clofazimine, from Barry's work, and in the Nigerian research centre at Uzuakoli, in the 1960s. More to the point, at a time when the balance in medical research was shifting ever more decisively from the clinical to the laboratory-based, and the clinical trial took its place, as an ancillary of healing, among the range of technical operations performed in expanding colonial healthcare institutions, the trial of B.283 at the RCM Ogoja leprosy scheme provided an especially eloquent index of the plans, aspirations and capacities of even the youngest and most remote of medical enterprises.

The less than ideal physical and geographical circumstances of most leprosy research, the impossibility of cultivating leprosy outside a living human host, the notion of separable epidemiological terrains, and the consequent privileging of local clinical knowledge - at times promoted in the most wilful terms - all help understand the experimental clinical setting of Ogoja as characteristic rather than anomalous. The remarks and publications of the Drs. Barnes, and the themes in their running correspondence with Barry and with Dr. Denis Freeman, Joe Barnes' successor as medical superintendent at the RCM Ogoja leprosy scheme, demonstrate in detail the reactions of a small and maturing medical enterprise to a global therapeutic shift in the technologies of leprosy control.

Chapter Seven - Leprosy control, mission, and decolonisation in Ogoja Province, 1953-1960

Statistical introduction

As outlined in the introductory methodological section, the statistical material available for an assessment of the success of either evangelism or RCM leprosy control in Ogoja Province prior to 1960 is inconsistent. With regard to incidence of leprosy, statistics in the early years tended to be gross, taking into account the distinction between the majority inpatients and a small number of outpatients. From time to time a note is appended on what treatment is being administered,[1] or where the grants are coming from, but the impression is of a form of document which expands and contracts in direct response to particular local and contemporary conditions, rather than in response to any broader epidemiological imperative. At the same time, there are some broad conclusions that can be drawn at this stage from an examination of such statistics as are available to us.

[1] Ogoja Convent Files. Annual Report 1948. The Roman Catholic Leper Settlement, Ogoja. This report notes that Chaulmoogral [sic] Oil was the main from of treatment, with some experimental work taking place on Promin. Chaulmoogra Oil, injected intradermally, was the treatment of choice in Nigeria between 1936 and the late 1940s in the absence of a better option, though its effectiveness was always in doubt.

	Ogoja			Obudu			Abakaliki			Ikom			Total		
Year	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total	Inpatient	Outpatient	Total
1945	510						230						740		c. 2500
1946	1073	8	1081	120		120							1193	8	1600
1947															
1948													2791	144	2935
1949													2738	150	2888
1950													2270	130	2400
1951													2620	694	3314
1952			2858			381									3239
1953	2184	447	2631	301	136	437							2485	583	3068
1954	1788	475	2263										1788	475	2263
1955	2224	781	3005						4000			1000			8005
1956			3979						4600			1000			9579
1957			4763						6313			1400			12476
1958	1830	3953	5783						6313			1000			13096
1959	1354	6128	7482									1814	1354	6128	9296
1960	1450	7316	8766									1860	1450	7316	10626
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P

Table 2: patient statistics - RCM leprosy control areas, Ogoja Province[2]

Table 2 consists of figures gathered from the files of the MMM Convent, Ogoja, relating to the numbers under treatment in the province as a whole. At various times, statistics were collated from up to four separate areas defined for the purposes of administering leprosy control, as indicated. The most consistent run pertains to the Ogoja Leprosy Settlement, though while leprosy control around Obudu was administered from the RCM general hospital there, the segregation village at Obudu did not constitute a settlement for official purposes, and thus statistics relating to Obudu were usually compiled along with those from Ogoja. From an early stage, Abakaliki Leprosy Settlement was administered separately –

2 Ogoja Convent Files. Annual reports (Obudu, Ogoja and Abakaliki Divisions, 1945; Ogoja and Obudu Divisions, 1946; RCM Leprosy Settlement, Ogoja, 1948-1950 – it is implicitly indicated in remarks appended to these reports that Obudu and Abakaliki figures are compiled into the overall figures presented; Ogoja Leprosy Settlement, 1954-55, 1958-60); Leprosy returns 1950-1951 – Ogoja, Obudu and Abakaliki; Table - 'Number of patients taking treatment – 1952 Feb.' - Ogoja and Obudu; Table – '1952-53 New cases: No. in treatment: new – diagnosed, admitted'; Ogoja Leprosy Scheme – summary of work at Ogoja, Abakaliki and Ikom, with figures for 1946, 1955-58 (the figure for Abakaliki in 1957 is repeated for 1958, and is included here as an indication of scale); UNICEF leprosy statistics – report from Ikom, 1959-1960.

between 1948 and 1954, and again from 1958 when Abakaliki Province was created, totals published for the RCM Ogoja Leprosy Scheme did not include figures from Abakaliki. In compiling this table, I have favoured annual reports on leprosy control activities over articles in missionary publications and statements in private correspondence, though there are instances in which the figures are reconstructed from notes made for the compilation of missing reports. The relatively poor communications between Ogoja, and Abakaliki and Ikom are reflected in the suspiciously rounded data presented for the latter settlements in the late 1950s.

These caveats aside, the table corroborates the propositions that a rapid shift towards outpatient treatment coincided in time with case-finding developments associated with the UNICEF Yaws Surveys described below, and that leprosy control coverage in Ogoja improved radically towards the end of the colonial era, as figures under treatment began to approximate to the prevalence of leprosy which had always been assumed by medical workers. The processes of expansion, consolidation, and control discerned by medical missionary observers can be read from rates of change in patient numbers, though extenuating difficulties regarding both the rapidly changing circumstances under which leprosy control was carried out, and the compilation of the statistical measures themselves must temper the conclusions that can be drawn from this data.

The patient numbers take on a new significance when examined in association with population figures from the Nigerian Census of 1953, indicating that up to 3.5% of the total population of Ogoja, Obudu and Ikom Divisions may have been receiving treatment for leprosy at any one time by 1960. This gives weight to the argument that, in administering leprosy control for these three divisions, and for Abakaliki, the RCM were engaged in one of the most significant and high-profile colonial interventions in the Ogoja area.

Division	Population	Pop. Density
Abakaliki	473000	99
Afikpo	247000	131
Obubra	104000	42
Ogoja	149000	39
Obudu	58000	17
Ikom	52000	16
Total pop.	1083000	

Table 3: Ogoja Province population figures from 1953 Census[3]

Year	1948	1949	1950	1951	1952	1953	1954	1955	1956	1957	1958	1959	1960
Admissions	548	474	140			382	412	661			2736	2144	1414
Discharges	84	72	50			279	14	77			258	173	1015

Table 4: patient admissions/discharges: Ogoja LS (comprising Obudu)[4]

Figures for the whole of the Eastern Region, dating from 1951 to 1953, and provided in Table 5, demonstrate a number of trends in the field of leprosy control as a whole. Firstly, the number of patients treated by the [Nigeria] Leprosy Service, in Owerri and Onitsha Provinces was decreasing, as were the numbers diagnosed, while numbers discharged rose. The high ratio of treatment centres to settlements is reflected in the preponderance of unsegregated patients in these Government-run centres. Though these figures are not decisive in their indications of any definite trend, they do seem to corroborate T.F. Davey's proposition that 1950s Eastern Nigeria was emerging from a leprosy epidemic, with numbers in sharp decline.[5]

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3 Y. Karmon, *A Geography of Settlement in Eastern Nigeria*, (Jerusalem, 1966), p. 40. These figures were adjusted by Karmon to take account of boundary changes in Ikom and Obubra associated with the creation of Abakaliki Province and with late colonial and post-Independence regional reorganisations.

4 Ogoja Convent Files. From annual reports for Ogoja Leprosy Settlement (i.e. not including Abakaliki and Ikom) – see note 2 above for details.

5 T.F. Davey, 'Editorial: Common features in rapidly declining leprosy epidemics', in *Leprosy Review*, 46,1 (March 1975), p. 5.

	1951-52			1952-53		
	Leprosy Service	N.A. And Voluntary Agencies	Total	Leprosy Service	N.A. And Voluntary Agencies	Total
Settlements	3	5	8	3	7	10
Segregation Villages	106	18	124	112	22	134
Treatment Centres	113	25	138	129	31	160
Segregated Patients	5548	10362	15810	6510	8691	15201
Unsegregated Patients	13784	1534	15318	9658	2845	12503
New cases diagnosed	4262	3013	7275	3457	3549	7006
Patients discharged symptom free	5031	1237	6268	5391	1067	6458

Table 5: Leprosy control statistics for Nigeria: Eastern Region[6]

The disproportionate tendency towards segregation among the Voluntary Agency and Native Administration schemes can in part be attributed to the funding discrepancies brought about by a focus on developing Government schemes over the first decade of the Nigeria Leprosy Service, but it also reflects the relative youth of some of these schemes, most notably those in Ogoja Province, where, as has been shown, the numbers under treatment continued to rise throughout the late colonial period. The rapid expansion of missionary-run treatment centres in the late 1950s, indicated in Table 6, points, in gross outline, to a similar overall life-cycle among both Government and mission schemes, though the contribution of WHO technical assistance and yaws surveys to the strategic shift in mission-run schemes, as described below, introduces an unquantifiable variable into such simplified correlations.

	1945	**1950**	**1955**	**1956**	**1957**	**1958**	**1959**	**1960**
Settlements	2	2	3					
Segregation Villages	7	8	6		14	16		19
Treatment Centres			12		28	39		39

Table 6: RCM institutions and centres for treatment of leprosy, Ogoja[7]

6 Ogoja Convent Files. Eastern Region leprosy statistics, 1951-1953, ref. LRD/ICOO. This informtaion derives from a single document.

7 Ogoja Convent Files. Annual report, Obudu, Ogoja and Abakaliki Divisions, 1945; Leprosy returns 1950-1951 – Ogoja, Obudu and Abakaliki; Annual reports, Ogoja Leprosy Settlement, 1955, 1958-60; Minutes - 1st meeting of Local Leprosy Advisory Board, Ogoja/Obudu Area, dated 13th Nov 1957. The boxed area

The implications of these figures for Catholic missionary evangelism in Ogoja are difficult to discern. As can be seen from table 8, the number of Catholics in the Province was rising steadily, the figure for 1954 showing almost 55,000 Catholics, and Catholics-in-waiting, served by a rapidly growing institutional base – yet failing to increase the number of Christian families. From a population of over 1 million, the return on Catholic evangelical investment seems paltry in comparison to that on its investment in medical services.

Year	Catholics	Catechumens	Marriages	Churches and Schools
1948	9968	12298	57	219
1949	12436	13437	54	233
1950				
1951	13343	17718	96	275
1952	16005	20395	78	275
1953	18240	29640	118	344
1954	21113	34682	94	420

Table 7: data from RCM sacred returns for Ogoja Prefecture/Diocese[8]

As will be seen in the remainder of the chapter, the generation of reliable epidemiological statistics would require the intervention and assistance of the next crucial set of actors in the developing story of modern leprosy control, the World Health Organisation, and UNICEF.

comprising Segregation Villages and Treatment Centres from 1955 to 1960 indicates that only Ogoja and Obudu Divisions are taken into account in the compilation of these figures.

8 Ogoja Convent Files, Sacred Returns for RCM Ogoja Prefecture, 1949, 1951, and 1954. MMM archives, Drogheda. 1/Dio/8/200. Series of Sacred Return – Prefecture of Ogoja. 1949, 1952-54. Figures for 1948 are derived from a column in the 1949 figures headed '1948 increase'. Sacred returns highlight the number of Catholics, Catechumens, Cathechists, School pupils, and figures on the administration of Sacraments.

"The leper": an abstract African

A LEPER THANKS YOU

My days I pass in my house round and small,
It's all the world to me.
I love every inch of its warm mud walls
And its roof of fragrant thatch.

From its tiny porch I watch the life
Of the village folk as they go.
I join in their chat and they give me the news
Of the world I do not know.

For I'm a leper you'll never meet,
But I love you in my heart,
And I pray God to bless you, my friend far away,
For the comfort you give to me each day,
For the fresh, clean dressings and bandages neat
That you send to Ogoja, for poor lepers' feet.[9]

As with the figure of Akong in *Visitation*, his identity dissolving on admission to the leprosy village, the leper bound in bandages from Ireland, salutes a world from which he is irrevocably cut off. This process effectively signalled an abstraction of 'the African' which constituted the obverse face of a mission identity constructed in relation to the leprosy settlement village. Indeed, from a medical perspective, in the years prior to Nigerian Independence, the energies of RCM staff were directed to, and emphasis had been placed very much on, the leprosy settlement village. This closely policed construction had proven very fertile for propaganda purposes, generating tales of suffering and redemption, education and Baptism documented through the late 1940s and 1950s in film and in missionary magazines. However, through the 1950s, articles such as those by lay missionary teacher Lily Murphy in *The Medical Missionary of Mary*, providing vignettes of settlement life[10], no

[9] L. Murphy, 'A leper thanks you', in *Medical Missionary of Mary*, 14, 4 (May 1953), p. 5.
[10] See, for instance, L. Murphy, 'Where lepers walk: a visit to Ogoja Leper Village', in *The Medical*

longer reflected either the work being carried out in the Ogoja Leprosy Scheme, or the way in which its missionary staff wished to be portrayed.

The propaganda emphasis began, in the mid-1950s, to shift to the hospitals at Ogoja and Abakaliki Leprosy Settlements, which were presented as being at the centre of a variety of new surgical and rehabilitative techniques, practised by an international community comprised of women at once of religion and of science.[11] This reflected a growing desire to consolidate and preserve already-existing Catholic institutions, and the services these provided to a growing Catholic community, rather than persisting with the groundwork of evangelisation, and marked a step in the increasing politicisation of the Catholic Church in Eastern Nigeria.[12]

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, so neatly encapsulated in the poem with which this section opens, manifests its inconsistencies in the more personalised vignettes presented by Chambers and Murphy in the late 1950s. In these accounts, 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',[13] 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.'[14]

Missionary of Mary, 14, 2 (1953), pp. 11-15, and L. Murphy, 'Umaji - a leper from Ogoja Village', in *The Medical Missionary of Mary*, 15, 1 (1954), pp. 11-13.

11 *Medical Missionaries of Mary: Covering the First Twenty Five Years of the Medical Missionaries of Mary, 1937-1962*, (Dublin: Three Candles, 1962), pp. 81-93, comprising a picture essay, and a statement on missionary method which focuses on development and hopes for Africanisation almost to the exclusion of evangelical aims, demonstrates the growing centrality of medical practice in MMM consciousness of mission at this time.

12 See E.C. Amucheazi, *Church and Politics in Eastern Nigeria, 1945-1966: a Study in Pressure Group Politics*, (Lagos, 1986), and D.B. Abernethy, *Church and State in Nigerian Education*, (Ibadan, 1966) for a description of this process, arising largely from the concerns of lay educated Nigerian Catholics.

13 Sr. M.V. Chambers, 'The spoiled gown: a leper's story', in *The Medical Missionary of Mary*, 16, 10 (Nov. 1955), pp. 13-14.

14 L. Murphy, 'Our "Doctor" Effiong', in *The Medical Missionary of Mary*, 18, 5 (Jun. 1957), pp. 4-5.

Such presentations document the uneasy reception of Catholicism demonstrated in the title of a 1954 article by McGettrick entitled 'Christians - 21,000; Pagans - 970,000 in Ogoja Prefecture',[15] and of the status of 'leprosy patient' attached to residence in the segregation village.

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 Chambers' 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 Medical Missionary of Mary*, and slowly outnumbering them, are a succession of increasingly sophisticated attempts to present the curability of leprosy and the modernity of missionary health care to an Irish audience in the late 1950s, a time when Irish society was itself subject to immense social and intellectual upheaval.

The signal event which heralds both the optimistic reassessment of the potential for leprosy control in Ogoja Province, and novel ways of representing the enterprise to a donor public, is the first mass discharge of patients from Ogoja Leprosy Settlement on 14th December, 1953. As a result of the administration of 'one or other of the now famous Sulphone drugs – Sulphetrone (or "Petrol" as it is called by some of the patients), given by subcutaneous injection, or D.D.S. given orally twice a week',[16] a group of almost three hundred patients were selected for discharge by Dr. Freeman, and ceremonially addressed by McGettrick (whose only sorrow was that many of those discharged still suffered 'diseases of the Soul'[17]), and by Freeman. Presented with discharge certificates, they were enjoined to demonstrate to their neighbours both the curability of leprosy, and the desirability of have a treatment centre in each village across the Ogoja area.

The impact upon the tone of missionary propaganda was immediate, with articles on the

[15] T. McGettrick, 'Christians - 21,000; Pagans - 970,000 in Ogoja Prefecture', in *The Medical Missionary of Mary*, 15, 11 (Dec. 1954), pp. 2-3.

[16] Sr. M.F. Morris, '"Be thou made clean" (St. Luke, v. 13)', in *The Medical Missionary of Mary*, 14, 3 (Apr. 1953), pp. 4-10.

[17] ibid., p. 8.

vocational diversity and institutional innovation of missionary medicine punctuating representations of the MMMs through the remainder of the decade.

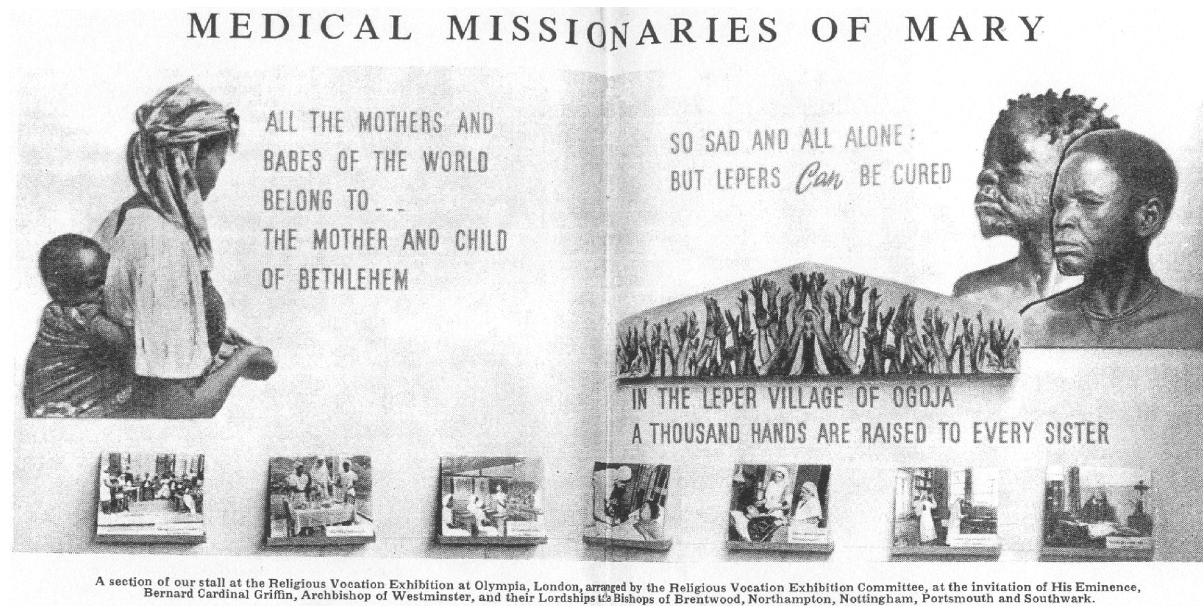

Figure 7: MMM stall for 1953 UK Missionary Exhibition[18]

A special edition of *The Medical Missionary of Mary*, issued in Jul-Aug. 1953, graphically presents this diversity on the opening page, where, arrayed alongside a prayer to Mary, and spelling out 'THE REALLY GOOD MISSION', are a list of medical and ancillary professions needed in order to keep the MMMs efforts in Ireland and Africa alive. In all, twenty-seven different roles are listed, from telephonists, elevator girls, and 'young assistants', to radiographers, architects, and surgeons.

By 1960, a radically different face of the MMMs, their aims, and their achievements on the mission was beginning to emerge. The transition can be traced in articles commenting on the Africanisation of politics and of welfare services,[19] the changing approach of the Catholic Church to medicine and surgery,[20] and the increasingly technical nature of the work carried

[18] In *The Medical Missionary of Mary*, 14, 7 (Sep. 1953), pp. 16-17.

[19] 'Young Political Africa: Young Suffering Africa: Young Constructive Africa' in *The Medical Missionary of Mary,* 18, 8 (1957), pp. 16-17, and 'Congress for Catholic Women of West Africa' in *The Medical Missionary of Mary,* 19, 6 (1958), pp. 14-16.

[20] Pope Pius XII, 'The Pope Speaks on Leprosy' in *The Medical Missionary of Mary* 17, 8 (1956), pp. 1-6, and F. Villela, 'The International Medical Missionary Association', in *The Medical Missionary of Mary* 17, 1 (1956), pp. 8-9.

out by MMMs in Nigeria.[21] The extent to which this constituted a rearguard reaction to the politics of development and healthcare in late colonial Nigeria, and the extent to which it emerged as part of a strategic repositioning of the Roman Catholic Church to the realities of decolonisation, will be the subject of the remainder of this chapter.

[21] Sr. M. Garnett, 'Some Problems of Maternal and Child Health in Rural Africa' in *The Medical Missionary of Mary* 17, 1 (1956), pp. 22-25, Sr. M.M. Nolan, 'The Apostolate of the Scalpel' in *The Medical Missionary of Mary* 18, no. 9 (1957), pp. 9-12, and Anonymous, 'Occupational Therapy' *The Medical Missionary of Mary* 20, no. 7 (1959), pp. 23-24.

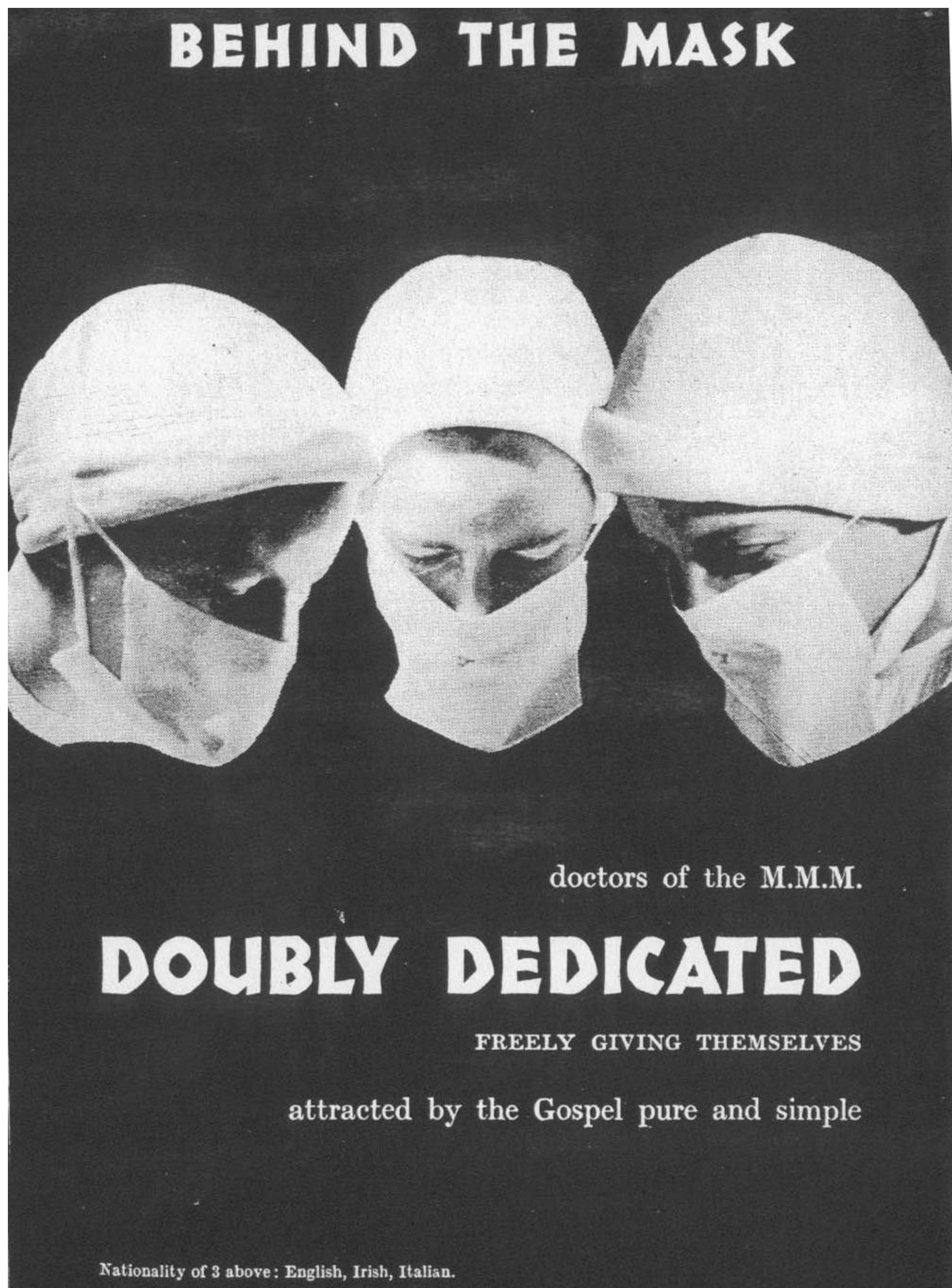

Figure 8: From *The Medical Missionary of Mary*, June 1960[22]

[22] *The Medical Missionary of Mary*, 21, 5, (Jun. 1960), p. 17.

The RCM and the emerging Nigerian political establishment

The address given at the opening of the new general hospital in Ikom on 21st Feb. 1956 by Dr. Michael Okpara, Minister of Health for the Eastern Region of Nigeria,[23] provided an opportunity for those present to reflect on the direction and progress of Nigeria as a new constitutional and political accommodation was being reached between Nigerian nationalists and the British colonial regime. The hospital itself was created through a joint venture of the Roman Catholic Church and the Government, with the financing being shared by Government and the local Council, and the management provided by the Church. This venture represented a new type of relationship between voluntary agencies and the state in Nigeria, replacing an essentially informal process of negotiation and tendering for service provision which had previously existed.

Okpara made the significance of this new form of institutional relationship clear from the outset in his speech.[24] The central role of Government, which provided £25,000 of the £30,000 needed to construct the hospital, was emphasised, while the role of the Church was described variously and somewhat inconsistently as 'providing the houses for the principal staff' and '[having] supervised the construction and undertaken to run the hospital'. The contractual nature of the relationship was stressed, and it was insisted that '[to] ensure efficient maintenance the running of the hospital has for the present been handed to the Catholic Mission', who would be expected to be dutiful and faithful stewards 'so long as they are required to do so.'

From Okpara's viewpoint, the hospital formed part and parcel of an expanded rural health service, integrated with Government-led policies on preventive medicine. For the Ikom area, the priority for preventive medicine was seen to be in the area of leprosy control, which for

[23] Michael Okpara was a prominent Nigerian nationalist politician, later Premier of the Eastern Region under the federal system in independent Nigeria.

[24] 'Minister opens new hospital: team work praised', in *Catholic Life*, 11, 3, (March 1956), pp. 1, 8.

much of Ogoja Province had hitherto been entrusted to the Roman Catholic Mission, staffed by lay doctors from Ireland and Italy, and by doctors, nurses and administrators from an Irish missionary order, the Medical Missionaries of Mary. The influence of the Catholic Church in Ogoja Province had been on the increase since the appointment of Mgr. Thomas McGettrick, an Irish St. Patrick's Missionary priest, as Prefect Apostolic of Ogoja in 1940. The level of this increase can be gauged from the elevation of the Prefecture to full diocesan status and the consequent consecration of McGettrick as Bishop of Ogoja in 1955.

In the same issue of *Catholic Life*[25] which reported Okpara's visit to Ikom, letters were published from patients in Ogoja and Obudu Leper Settlements congratulating McGettrick on his newly elevated position. From Ogoja, Adariku, representative of the out-patients, wrote

> had it not been for your mercy to lepers, we would not have dreamed of the treatment; we get free today... without you most of us would be rotten ever since in the graves,[26]

while Benedict, writing from Obudu on behalf of the patients noted that

> [since] your absent [sic] of nearly a year ago there were crying from many patients who thought that they could not see you again. They were only cooled down when they heard you were not leaving them but was going home for your Consecration... the pride we felt for your Consecration exceeded expressing. The good work and your skilful responsibilities were noticeable in Ireland and that is why your Consecration was possible.[27]

Benedict's letter finished 'Viva la Eire', offering a 'small lamb for your entertainment'. A similar offering was made by leprosy patients in Ogoja, while the people of the parish of Kakwagom, which also housed a Roman Catholic Mission leprosy clinic, gave £5.

These divergent indications of the level of trust vested in the Roman Catholic Mission, by nationalist politicians and by rank-and-file Catholics, and the differing degree to which the mission could be said to have earned the support of various groups in Nigerian society are symptomatic of social and political transformations taking place throughout Africa in the late 1950s. While the Ogoja Leprosy Scheme expanded in scale and scope, moves were made across Eastern Nigeria to increase and formalise both the level and the impact of local

25 *Catholic Life*, 11, 3, (March 1956), p. 2.
26 ibid.
27 ibid.

consultation with regard to leprosy control. This went hand in hand with constitutional change across Nigeria through the 1950s which saw provision for elected councils in the Eastern Region from 1950, the abolition of the post of Resident in 1956 and 1957, and the instigation of a federal system for regional self-government in 1956. The effect of this change was to dismantle the unpopular native authorities, which were seen as deriving their authority from British colonial power rather than from any basis in local politics.[28]

On this unpredictable terrain, the RCM Ogoja Leprosy Scheme was an active participant in the shaping of the new accommodation between Nigerians and expatriates taking place at local, regional and national level across the country. Political and constitutional changes in Nigeria also had a crucial impact on the strategies available to and employed by Catholic missionaries in their attempts to maintain institutional continuity and stability. Transformations in the nature of the effective contract between mission and government, as hinted in Okpara's speech, altered the context in which Catholic missionary welfare services were provided, and in the case of leprosy control, interacted with fundamental technological and capacity changes to create a complex and, at times, fraught medical politics needing careful negotiation from all parties. Examined from the viewpoint of missionaries, this process sheds an interesting light on the processes of decolonisation and the politics of independence in Nigeria.

While the Scheme expanded in scale and scope, moves were made across Eastern Nigeria to increase and formalise both the level and the impact of local consultation with regard to leprosy control. Thus, a 1956 proposal to the Eastern Region Leprosy Advisory Board that a member from each Province be chosen to sit on a board hitherto almost entirely consisting of European administrators, medical experts and missionary representatives betokened a process of Africanisation proceeding at a rapid pace throughout government services. That the board in question was consultative and advisory, and that the Nigerians representing the Provinces would be nominated by interested parties[29] was also very much along the lines

[28] Royal Institute of International Affairs, *Nigeria: the Political and Economic Background*, (1960), p. 67.

[29] Ogoja Convent Files. Minutes of the [fifth?] meeting of the Eastern Region Leprosy Advisory Committee [sic], February [1956], paragraph 5. 'It was agreed that the membership of the committee be extended to

evolving under the late colonial regime.

At the same time, it was envisaged that these representatives would be at The parapet of a broader effort at consultation, reaching down to Province, and further to Divisional or County level: the same meeting recommended that local advisory boards would be set up to bring together local representatives, government medical officers and advisors, leprosy superintendents and mission representatives, in order to discuss issues of local importance regarding the development and use of hospitals and dispensaries. The Leprosy Inspectors Training School at Oji River had become a Rural Health Training School,[30] and it was envisaged that Leprosy Attendants would be absorbed into the newly transformed Rural Health Service which was evolving out of the dispensary system.

The appointment of a representative on the Eastern Region Board from Ogoja Province was not straightforward. The Leprosy Adviser, K.S. Seal, at the Rural Health Headquarters in Oji River, wrote to Sr. Visitation Chambers, the Medical Superintendent of the RCM Leprosy Settlement in Ogoja, asking for a recommendation from Ogoja, Ikom and Abakaliki. Chambers referred the matter to McGettrick, who wrote in reply:

> It is hard even to think of anyone who is literate but who is not directly associated with the mission and at the same time has an interest in public affairs.[31]

All the same, it was agreed that Peter Abue, a district councillor from Mbube, near Ogoja, would be recommended. The Ogoja nomination was noted as awaiting approval at the February 1958 meeting of the Eastern Region board, and was not in evidence at the July 1959 meeting. It was not until the 1960 meeting that confirmation was received of a representative from Ogoja Province, one E.M.A. Ogar, noted as the Ikom representative.

The attitude of the RCM towards county and divisional leprosy advisory boards was similarly cautious, if not downright dubious. Chambers was reported as saying in 1959 that

> from her experience [the boards] were not very helpful. She preferred dealing direct with the District

include one member from each Province, to be appointed by the Hon. Minister of Health on the recommendation of the Medical Officer in charge of Leprosy Control in the Province.'

[30] ibid., paragraph 6.

[31] Ogoja Convent Files. Letter from McGettrick to Sr. Visitation Chambers, dated 4th Oct., 1957.

Councils at their general meetings which brought personal contacts with important personalities.[32]

Though the early meetings of these boards were inconclusive, consisting mostly of reports on the work in hand at Ogoja, Ikom and Obudu given by the medical superintendent, and complaints about withholding or diverting of funding thought to be properly the due of leprosy control work, varieties on Ogoja divisional and local leprosy boards continued to meet into the 1960s, with increasingly elevated local representation in the guise of heads of councils sitting alongside the various medical personages.

Global public health and local leprosy services

By mid-1952, with the government Nigeria Leprosy Service operating for seven years, and reporting startling success in combating leprosy, it was clear that the highest remaining incidence of leprosy was in Ogoja Province,[33] and at the encouragement of Dr. Freeman, the representative of the Catholic Mission and of the RCM's Leprosy Control Scheme in Ogoja, a resolution was passed to call on Government to increase contributions to voluntary agencies involved in leprosy control. By 1953, the possibility that UNICEF would provide specific leprosy drugs was seen as freeing up potential funds for the expansion of voluntary agency leprosy control, and as this possibility came to fruition in the next few years,[34] government aid to voluntary agencies increased substantially. The commitment of government to this form of funding was underlined by its inclusion in proposals for 1956-60 Development proposals.[35] Support from local government was noted to be on the increase, and the efficacy of the various advisory bodies in securing advantageous trading and warehousing conditions for leprosy-related projects helped streamline the ongoing

[32] Ogoja Convent Files. Minutes of the eighth meeting of the Eastern Region Leprosy Advisory Board, 3rd July 1959, paragraph 3-3(d).

[33] Ogoja Convent Files. Minutes of the third meeting of the Central Leprosy Board, Lagos, 20th May, 1952. Paragraph 3 paraphrases the remarks to this effect of the new Leprosy Adviser, T.F. Davey.

[34] Ogoja Convent Files. Report on Leprosy Control – Eastern Nigeria 1960. Section 1 introduces the history of leprosy control in the Eastern Region of Nigeria to 1960, and states: 'On 30/4/1954 the Government entered into and Agreement with the World Health Organisation and UNICEF for assistance in the expansion of the Programme and this most fruitful arrangement has enabled the work to proceed more effectively and in a much more extensive way than would have otherwise been possible.'

[35] Ogoja Convent Files. Proceedings of the fourth meeting of the Central Leprosy Board, Enugu, 9th Nov, 1954, paragraph 3.

development and expansion of leprosy control.

The impracticality of conducting a full population survey as an adjunct to leprosy control had been acknowledged by Barnes in 1945. Issues of cost and consent had been cited, and in the circumstances of the time, it had been decided to grow the work from seed, gradually establishing complete coverage. An important boost in the effort to extend this coverage was received in the shape of the UNICEF-funded Yaws Treatment Surveys undertaken in Eastern Nigeria from 1954. The procedure for yaws surveys entailed an initial treatment survey (ITS) followed by more complete resurveys and penicillin treatment, ensuring a house to house coverage.[36] On the basis that surveys attempted to identify skin lesions, this was integrated with case discovery for leprosy, and cases of leprosy discovered in this way were referred to leprosy settlements across Eastern Nigeria throughout the late 1950s and early 1960s.

A note from 1956 describes the expanding leprosy service as

> the work of eighteen Sisters, four lay doctors, one lay teacher and one lay nurse, helped, of course, by 100 African nurses.[37]

The quoted passage forms part of a description of the growth in the number of leprosy and general consultations in the previous two years, when the number of resident leprosy patients at central settlements and segregation villages grew from 8,100 to 9,000, and the number of leprosy consultations from 32,000 to 34,000. This sign of commitment is reflected by the long service of Sr.Visitation Chambers, who worked in Ogoja as a leprosy doctor and medical superintendent from 1948 to 1974. The involvement of the Medical Missionaries of Mary, during a period which saw the congregation grow in numbers and in geographical spread, greatly aided the international profile of Catholic mission leprosy control. This profile bore fruit in the aftermath of the 1948 film Visitation, with its focus on Ogoja, and with links between the MMMs and the Archdiocese of Boston, and, from 1955, between the newly-created diocese of Ogoja and Catholic funds and charities worldwide.

Amid a seemingly rapid increase in new cases, in 1957 McGettrick, now Catholic Bishop of

[36] 'Report of Second International Conference on Control of Yaws: Nigeria, 1955', in *The Journal of Tropical Medicine and Hygiene,* Vol. 60, No. 2, (Feb. 1957), pp. 27-38 and No. 3, (Mar. 1957), pp. 62-73.

[37] M. Mary Martin, 'Editorial', in *The Medical Missionary of Mary*, 17, 2, (1956), p. 2.

Ogoja, penned a chastening meditation on the progress achieved in twelve years of Catholic missionary leprosy control in the north of the Province. Quoted in *The Medical Missionary of Mary*, he wrote:

> There are three stages in the elimination of leprosy: the first when every patient has a treatment centre near him; the second when all are receiving treatment and all the infectious cases are segregated; and the final stage when it is completely wiped out except for the few burnt-out cases in the segregation villages. It takes at least twenty years to reach the second or control stage when there will be no new cases - we have not yet completed the first step. It takes at least a century to arrive at the complete elimination stage. New cases are coming in every day in Ogoja.[38]

Concurring with the growing recognition that, by the mid-1950s, Ogoja Province represented Eastern Nigeria's most persistent reservoir of new leprosy cases, McGettrick's assessment was targeted at a Catholic readership proud of 'the heroism of her missionaries'[39] and willing to fund the works of these missionaries. His brief and strategically pessimistic overview of the process of leprosy control introduced an article by Sr. Visitation Chambers, the Irish doctor in charge of the RCM leprosy control programme in Ogoja, where the day-to-day running of the programme was described in some detail.

The tone of Chambers' article is testament both to the relative isolation of Ogoja in the colonial scheme, and the manner in which the Catholic Church interpreted its own provision of welfare services. While the RCM Ogoja leprosy control scheme, which had primary responsibility for leprosy control in the north of Ogoja Province, resulted from a process of negotiation with the British colonial administration in Nigeria, and operated along lines agreed with the Nigerian Leprosy Service, using funding and medical capacities provided by a variety of organisations, little mention is made of the role of any external organisation. There is mention of 'quite a volume of official correspondence to cope with',[40] while the beneficent effect of a BELRA child adoption scheme is briefly mentioned as a consolation and a boon in providing extra food to school-children cared for and educated in the leprosy settlements. The work which forms the focus of the article, comprising supervision, education, management, and training for auxiliary African staff mostly drawn from among

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38 Quoted in Sr. M.V. Chambers, 'Leprosy in Ogoja', in *The Medical Missionary of Mary*, 18, 7 (1957), p. 11.

39 J. McGlade, *A History of Irish Catholicism: the Missions: Africa and the Orient*, (Dublin: Gill and Son, 1967), p. 17.

40 Chambers, 'Leprosy in Ogoja', (1957), p. 19.

the patients, is represented as an outgrowth of a successful and well-organised religious mission.

Concluding her report on the development of leprosy control in Ogoja, Chambers remarks on the need for more specialised workers to administer ancillary diagnostic and therapeutic services. Commenting that '[as] ever in the Lord's vineyard, the harvest is great - the labourers all too few',[41] she effectively recapitulates the longstanding bind between missionary Christianity and leprosy work noted in both contemporary reports and more recent scholarly accounts. Writing in 1951, Patrick Myers noted that religious organisations tend and maintain patients in most leprosy colonies worldwide, even in government-supported institutions, adding that 'the Catholic Church alone has the credit of maintaining the largest number of such institutions - no fewer than 108 throughout the Mission world'.[42]

More recently, Zachary Gussow claimed that, as a result of missionary involvement, 'the care of lepers has evolved into a distinct and separate social and medical service, with its own outlook and tradition, its own staff structure and funds, and its own vested interest',[43] a point underlined in the case of the Cross River region of Nigeria by Irene Brightmer, who described how leprosy 'accidentally became a “different” disease with a religious identity'.[44] In this way, it can be seen how Catholic missionary organisations such as St. Patrick's Missionary Society, Kiltegan, and the Medical Missionaries of Mary occupied the decontextualised rhetorical space defined by their relations to European and North American patrons and donors, and their appointed missionary fields.

Thus decontextualised, the dynamics of historical change with regard to leprosy control in Ogoja as represented in missionary narratives suffer from a failure to appreciate how decisive shifts in medical practices and resource allocation were effected in response to broader currents in international medical politics. More seriously, however, the scholarly literature on leprosy control has contributed to a perpetuated sense of 'difference' in its failure

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41 Chambers, 'Leprosy in Ogoja', (1957), p. 22.
42 P. Myers, *Uplifted Hands: the Story of Leprosy*, (Tralee, 1951), p. 64.
43 Gussow (1989), p. 223.
44 Brightmer (1994), p. 65.

to interrogate the patterns of change in global medicine and public health since 1945. Gussow, for instance, assumes that global health bodies wrested the reins of leprosy control from missionaries and imposed a new formation on its practice.

In respect of characterising difference, Megan Vaughan has shown that the impetus to differentiate between diseases and between locales informed medical thinking far beyond the field of leprosy control in 1930s colonial Africa.[45] Through the 1950s, it could be said that leprosy was becoming less 'different', and the services concerned with its control less distinct from other medical services, but this diminution reflects similar processes in the control of trypanosomiasis, syphilis, and tuberculosis, among others. In leprosy control, as elsewhere, much of the impetus for this transition came from without the mission-government axis with which this thesis has been concerned to this point.

In the aftermath of World War Two, organisations emerging from the United Nations (UN) structure, such as the World Health Organisation (WHO), aspired to be truly global in scope, and other UN agencies such as the United Nations International Children's Emergency Fund (UNICEF) rapidly developed a global presence over the next twenty years. Organisations such as BELRA, in its various incarnations, were relatively disadvantaged by confinement in geographic scope to the admittedly extensive boundaries of the British Empire. On the other hand, Catholic organisations such as the Kiltegans and the MMMs, though they administered their establishments on a local basis, largely independent one from the other, were answerable both to Church authority derived from the Vatican and to religious and financial patrons across a variety of locations.

For both BELRA and the Medical Missionaries of Mary, much use was made of the fact that, as Maggie Black writes:

> The image of the suffering child is one of the most potent images of the 20th century. The child in distress is often used as a visual symbol for far larger issues: war, famine, pestilence, catastrophe, poverty, economic crisis.[46]

The explicit connection made between children in donor countries and children in Africa and

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45 Vaughan, (1991), and in personal conversation with the author.
46 M. Black, *Children First: the Story of UNICEF, Past and Present*, (Oxford, 1996), p. 6.

in Ogoja served to highlight the recognition that 'children are the key point in the attack on the disease'.[47] A later edition of the BELRA Annual Report mentions the involvement of schools, Sunday schools and scout groups in fund-raising,[48] while the MMM periodical, *The Medical Missionary of Mary*, ran a regular children's page with stories, competitions and messages of gratitude for funds raised from individual children and from groups. The connection made thus would continue to be at the forefront of propaganda on leprosy throughout the period under consideration. As disease control policies changed, with the development of sulphone therapy and the subsequent possibilities of mass discharge from leprosy settlements and the shift away from segregation-based schemes, BELRA was in many ways a bridgehead between these old *cordon sanitaire* and segregationist policies and new policies aligned with WHO/UNICEF mandates.

The continued salience of child-centred initiatives adds to a sense of continuity across the diversity of programmes in place in the 1950s, a continuity underlined by the experience of leprosy control in specific locations. For the Medical Missionaries of Mary, and the Roman Catholic Mission in Ogoja, the funding provided by BELRA and by UNICEF, as well as the advice and expertise made available by the Nigerian Government, assisted in the elaboration of a programme that married the specifically Catholic concerns of evangelism and of denominational health services with a response to the health care needs of local communities. The way in which this marriage was understood shifted in response to changes in the medical engagement with African communities as global resources were focused in earnest on the areas and groups with whom the missionaries had long been in contact.

Though BELRA was essentially an agency of informal empire, its international scope put it in an interesting position with regard to UN-related agencies emerging from the post-war political world. In 1953, the Medical Secretary of BELRA undertook a leprosy survey for the WHO in Turkey, and became Technical Medical Adviser to the American Leprosy Missions, as well as co-operating with colonial governments in setting up leprosy research centres in

[47] *British Empire Leprosy Relief Association. Annual Report*, (1947), p. 7.
[48] *British Empire Leprosy Relief Association. Annual Report*, (1955), p. 4.

Uzuakoli and in East Africa. In this regard, it had an important role to play in the development of the institutional capacity which would be both harnessed and extended in the period of mass disease campaigns inaugurated by the WHO and other international UN-related bodies in the 1950s.

Maggie Black refers to the disease control schemes of the 1950s as 'this huge and theatrical health exercise' and mentions UNICEF's role as 'only one player… but an important one'.[49] Leprosy control in the years after World War Two offered players a 'theatre' in more than one sense, where intense dramas were played out both as on a stage and as in a war. The stage for this theatre was set by the developing capacities for intervention of powerful global health and welfare bodies funded by donor governments in the aftermath of World War Two.

The intervention of UNICEF and WHO in Africa in the 1950s was problematised by the political status of much of Africa, it being under 'metropolitan' colonial control. As Iskander writes,

> The Metropolitan powers at the time were reluctant to encourage 'interventions' by the United Nations and its specialized agencies. They had their own plans for the development of their territories and since 1946, in the face of growing national agitation, had made funds available for ten-year programmes aimed at the development of economic resources and the raising of living standards in Africa.[50]

It was also crucial that methods of cooperation, both between WHO and UNICEF (as technical and material aid bodies, respectively) and between these bodies and other groups engaged in disease control and preventive medicine, be elaborated through the process of engagement with bodies on the continent – colonial powers 'wished [technical and humanitarian] agencies to integrate their own efforts in to the existing development programmes rather than initiate new efforts'.[51]

The template for this engagement had already been set in other parts of the world. The cooperation between the WHO and UNICEF, initiated in 1948 at the request of the Yugoslav Health Administration in response to problems posed by endemic syphilis in post-war

[49] M. Black, *The Children and the Nations: the Story of UNICEF*, (Sydney, 1986), p. 90.
[50] M.G. Iskander, *UNICEF in Africa, South of the Sahara: a Historical Perspective*, (New York, 1987), p. 1.
[51] Iskander, (1987), p. 2.

Bosnia,[52] developed further through the early 1950s. Mass campaigns against the endemic treponematoses, of which yaws and syphilis were examples, were undertaken in Haiti and Indonesia. In the latter case, successful use had been made of an already exiting rural health scheme. The success of these campaigns had a number of implications for leprosy control in Eastern Nigeria, and impacted strongly on the pace of expansion of leprosy control in Ogoja. The most obvious impact is described in the following passage from a survey of the first decade of WHO:

> The field work [in the Eastern Region of Nigeria] has been done by teams of from ten to fourteen trained auxiliaries… The co-operation of the people has made it possible to call together 1000 to 1500 persons at one time… A survey for leprosy and mass immunization against smallpox and yellow fever are carried out at the same time.[53]

The referral of suspected leprosy cases in the Ogoja, Ikom and Abakaliki Divisions of Ogoja Province to local leprosy settlements helped increase the coverage of the Ogoja scheme, and prompted a rapid growth in the number of treatment centres and clinics attached to the scheme.

WHO-UNICEF co-operation also impacted directly on the treatment of leprosy. With the report of the WHO expert committee on leprosy presented in Rio de Janeiro in 1952, a strong boost was given to the emphasis on sulphone therapy, and specifically on diamino diphenyl sulphone (dapsone), already evident in the Nigerian leprosy control programmes. The subsequent material assistance programme whereby UNICEF provided sulphone tablets to the Nigerian leprosy control programme from 1954 freed government resources and aided the development of capital programmes, both through the donation of transport and by providing the government with the opportunity to channel funds into building programmes for a growing rural health service. Also for the first time, with the epidemiological machinery of UNICEF, a detailed picture emerges of the rates of default, the age and sex profile of the patients, and the course of the infection in an individual under treatment.[54]

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[52] World Health Organisation, *The First Ten Years of the World Health Organisation*, (Geneva: WHO, 1958), pp. 202-03.

[53] World Health Organisation, (1958), pp. 204-05.

[54] Copies of many of the returns compiled for UNICEF by the Ogoja Leprosy Scheme are still to be found at the MMM convent in Ogoja. The details of default rates, age profile and sex are provided, as are numbers referring to in- and out-patient status, all of which was crucial to the development of sensitive disease control policy instruments in the 1960s.

The effect of the increase in funding and resources can be seen in startling fashion from figures presented to the Eastern Region Leprosy Advisory Board meeting in 1959. The report on Ogoja Province shows that in the Abakaliki division alone, eight new treatment centres had been opened, bringing the total number to twenty and reaching the greatest number of patients of any divisional service in the Eastern Region. In Ogoja Division, a new segregation village was opened alongside ten new treatment centres, bringing a further 1,000 patients under treatment, while Ikom saw the opening of seven new treatment centres visited weekly by a Nursing Sister, as a result of a new road facilitating access to the north of the Division. The utility of the UNICEF Yaws Survey in case discovery was acknowledged, and great things were hoped for when the Mobile Field Unit attached to this survey visited Ikom during 1959.[55]

The UNICEF returns, filled in and returned from the mid-1950s onwards, separate patients into classes, whether new or old patients, whether defaulters reinstated, relapses or transfers, whether children, women between 16 and 40, women over 40, or men. These statistics were useful in tracking the success of various outpatient and inpatient strategies and in generating an overall view of the work conditioned less by the imperatives of a local situation or the agendas of a particular doctor. The multiplication of categories amid the target population also assisted in the development of therapies according to perceived need – the small number of inpatients could be dealt with on a more personal level, and patients referred for surgery and rehabilitation could be assured that attempts were being made to address their needs as a group.

The expansion of the late 1950s, and the focus on developing treatment centres rather than segregation villages, brought Ogoja in to line with the trends towards outpatient care seen somewhat earlier in the Government-run schemes. One result of this was that the engagement with patients, sustained and intense in the early years of the Ogoja scheme, typically became less intense and more of a piece with everyday life. A description of the

[55] Ogoja Convent Files. Proceedings of the eighth meeting of the Central Leprosy Board, Oji River, 3rd Jul, 1959. paragraphs 2.4.1 - 2.4.3.

work at Ogoja in 1964 notes that:

> A leprosy attendant and a dresser attends [sic] the Segregation village and treatment centre. Ulcers are cared for only at the villages, only able bodied patients attend treatment centres and they do so with minimum disturbance of their life two visits a week and patients do not have to travel further than 3 miles to a centre.[56]

an observation which is very much at odds with the portrait of evangelical opportunity suggested in the film Visitation, a mere 17 years earlier.

It is perhaps unsurprising then that the medical establishment seemed less a site for evangelism than a locus of new technologies and interventions in the social order, and that the focus of missionary staff often seemed to be on perfectibility of medicine as charity as well as on the personal spiritual journey. In this respect, it could be said that the MMMs were engaged in self-consciously transforming medicine as well as mission - as the MMM silver jubilee publication states,

> ..it is no use having a hospital, clinic or dispensary without at the same time looking into the real needs of the neighbourhood, because medical care that does not integrate this battle against ignorance would be unrealistic and too academic.[57]

Reframing religion and medicine

For the Medical Missionaries of Mary, the experience of the 1950s led to a new focus on the links between religion and medicine. While a strong sense of these links had always been at the heart of the congregation's self-conception, the era of African independence and of new understandings of international aid and development seemed to put new medical services and ideas at the vanguard of a politics of identity which drew European missionaries and African families and communities together. Thus an MMM commentator writes:

> modern methods of treatment of their everyday maladies… are slowly but surely drawing… our people away from their superstitious practices and erroneous conceptions and making them seek remedy for sickness and ill health in the hospitals and clinics.
>
> In their enlightenment, they see beyond such renowned personages as Professor Rontgen, and Pierre and Marie Curie, the Omnipotent God who has fashioned and shaped such superior intellects, and

[56] Ogoja Convent Files. Copy of letter dated 19th Feb 1964 describing Ogoja leprosy work, from the Medical Superintendent.

[57] *Medical Missionaries of Mary: Covering the First Twenty Five Years of the Medical Missionaries of Mary, 1937-1962*, (Dublin: Three Candles, 1962), p. 67.

> whom they wish henceforth to serve.[58]

The increasing specialisation of MMM medical workers as women of science, operating as educators and development professionals,[59] evolved alongside changing patterns of international intervention in African health care issues. The growing co-articulation of science with religion visible in MMM publications from the late 1950s, while not explicitly acknowledging the contribution of international organisations to the medical work of Catholic missions, complicates the simplistic readings of missionary rhetoric which resulted in ahistorical hagiographies of missionary enterprise.

This intellectual shift in late-colonial mission took place against the backdrop of immense changes in African politics. To what extent, then, was Independence a watershed for Catholic missionaries working in Eastern Nigeria? It was certainly a marker of anxiety, brought about in part by the experience of increased Nigerian involvement in welfare and development politics. Okpara's speech demonstrated what the significance of Nigerian ownership of services might be: that the missionary contract to run educational and health services, informal in spirit if not in letter under the British administration, might become both circumscribed and revocable. The suspicions and fears are clearly expressed in a diocesan circular issued by McGettrick in Ogoja in January 1959, with the purpose of outlining a programme for Catholic Action in the diocese:

> The Communists say: 'tomorrow the world will be ours'. They seem to be on their way to make good their boast. In a single generation a small highly organised group have control of one third of the world's population… What the Communists have done in the world we must strive to do in Ogoja – bring the light of the Gospel to the majority of the people through an organised system of teaching Catechism; the few will instruct and save the many.
>
> Hitherto we have relied almost completely on the Schools for contacts and conversions. The system while it brought good results has inherent weaknesses and disadvantages.… it is as plain as a pike staff that the Councils and State will secularise the schools if and as soon as they can pay the costs of the schools without the assistance of the Managers. We should prepare for that contingency and have a subsidiary organisation established to meet that emergency; otherwise our whole conversion system may be stymied.[60]

[58] Sr. E. O'Mahony, 'Through medical science to Christianity', in *The Medical Missionary of Mary*, 19, 1 (1958), pp. 4-6.

[59] *Medical Missionaries of Mary: Covering the First Twenty Five Years of the Medical Missionaries of Mary, 1937-1962*, (Dublin, 1962), p. 67, gives an indication of the strategic vision for health care that had emerged from 25 years of practice in Africa and Ireland.

[60] Ogoja Convent Files. [Ogoja Diocesan] Circular No. 136, Thomas McGettrick, Bishop of Ogoja, January 1959. A copy was issued to each Catholic priest and nun in the diocese.

Indeed, Communism was not the only perceived threat emerging from the rush towards independence. Even the strategic second string of Catholic healthcare provision was experiencing the pincer pressures of Cold War politics. McGettrick writes:

> The country is changing overnight. One thing is clear that if we are to get any more Medical Institutions going we have to get them inaugurated now. Tomorrow will be too late. American Protestant Missionaries have begun to arrive here in greater and greater numbers. The USA has a Consul General in Lagos and a Representitive [sic] in each Region... They intend to play a stronger hand in the development of Nigeria. All kinds of family planning and use of contraceptives will be advocated on a wider and wider scale... To save our Christian Homes we need Catholic Hospitals and Catholic Doctors. We should have one in every Division.[61]

The difficulties encountered in providing Catholic services to the population of Ogoja are most clearly indicated by the overwhelmingly European profile of senior Catholic clergy in Ogoja. In 1957-58, one report has it that Ogoja had 48 European Catholic priests and 42 European nuns, with no Africans in either category,[62] though the maternity hospital in Kakwagom, between Ogoja and Ikom, had been handed over to a Nigerian order of nuns in 1956.[63] The first priest from Ogoja, the present bishop Joseph Ukpo, was not ordained until 1965.[64] The recruitment of women for the Sisterhood continued to be ad hoc right into the 1960s, with those applicants who presented themselves being sent to a Novitiate. In 1963 McGettrick decided to institute a new system of recruitment on a similar model to that of a seminary, with the aim of getting

> sufficient Native Sisters to staff our Hospitals, Girls' Schools and Colleges – and the Nigerianisation of our staffs is not only desirable but can almost be said to be necessary for the prestige of the Catholic Mission in the Country.[65]

This resolution, made in advance of McGettrick's departure for the first session of the Second Vatican Council, is of a piece with the Catholic Church's general reorientation towards Independent Nigerian politics, as reflected in the joint pastoral letter of the Nigerian hierarchy to the new nation's Catholics on October 1st, 1960. In this letter, the Catholic bishops claimed pride 'that [the Church's] contribution to education and her work of drawing

61 MMM archives - 1/Dio/8/159 - Letter from Bishop T. McGettrick to Mother Mary Martin, dated 29th Jan, 1959.
62 Amucheazi, (1986), p. 36
63 Ogoja Convent Files. Typescript entitled 'A brief history of the Medical Missionaries of Mary in Ogoja' (n.d. [1986?]), p. 10. Kakwagom maternity clinic was handed to the Handmaids of the Holy Child Jesus in 1956, and they built a novitiate there.
64 McGettrick, (1988), pp. 138-39.
65 Ogoja Convent Files. Letter dated 19th March 1963 from Bishop Thomas McGettrick to Mother Mary Martin, MMM Drogheda. This letter summarises the content of Diocesan Circular no. 150.

together into one social body people from all parts of the country' had assisted in achieving national independence.[66] The concerns of the Church for the continuation and stability of its influence in Africa, given local and international secularising pressures, add a certain piquancy to the vision presented here of the pressures and changes undergone by missionary services in the period of decolonisation.

For the Medical Missionaries of Mary, 1960 drew to a close amid an air of celebration. Headed with a picture of the smiling Governor General of Nigeria, Nnamdi Azikiwe, Martin wrote a letter of congratulations to 'Nigeria's rulers' on the occasion of 'the birth of the free nation of Nigeria', noting that:

> when you recall that our Congregation was born there you can understand Nigeria's special place in our affections... it gives me deepest pleasure to rejoice that we have lived to see this great day, 1st October, 1960.[67]

Much of the three editions of the MMM periodical published over the latter months of 1960, focus on the pageantry surrounding the newly independent nation. Facing a photograph of the Benedict Enwonwu sculpture of Anyanwu, Light of the Sun, designed for the forecourt of the new Museum in Lagos, is printed a specially composed papal prayer for Nigeria. Among the sentiments expressed is a call to

> [i]nspire our rulers to legislate for our temporal good ever in harmony with the Eternal Good for which Thou hast created us.[68]

The core of this valedictory conclusion to 1960 rests in the depiction of Ireland's celebrations of Nigerian Independence, which took place at the MMMs International Missionary Training Hospital in Drogheda. Alongside the Papal Nuncio, and the *Taoiseach* Sean Lemass, who himself had recently returned from Nigeria, were the 148 Nigerian university students in Ireland, the Education Attaché at the Nigeria High Commission in London, and the Minister of Information in the new Nigerian Federal Government, the Hon. T.O.S. Benson.[69] The ensuing gala, blending Mass and a reception, was an occasion to savour for the dignitaries of

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[66] *The Catholic Church in an Independent Nigeria: Joint Pastoral Letter of the Nigerian Hierarchy*, October 1st, 1960, p. 3.

[67] M. Martin, 'A letter of congratulations', in *The Medical Missionary of Mary*, 21, 8, (1960), p. 1.

[68] Pope John XXIII, 'A prayer for Nigeria', in *The Medical Missionary of Mary*, 21, 9, (1960), p. 2.

[69] 'Nigerian celebrations: the big day in Drogheda: special stories from Africa', in *The Medical Missionary of Mary*, 21, 10, (1960).

Drogheda.

Alongside this signal of the Catholic Mission's rather anti-climactic transfer of allegiances, were signs that the combat against leprosy continued apace. Chambers details the hope offered to her friend Gabriel:

> an advanced lepromatous case. The disease had progressed through the various stages of the macular lepromatous type... Gabriel first came to Wanakom in the Chaulmoogra oil days and was at a more advanced stage than [today]... Eighteen months ago a newer drug came on the market... Gabriel and [eleven] other severely affected patients were treated... They had fun rubbing the ointment into one another's backs... After four month's 'rubbing medicine' there was very evident improvement in Gabriel's case... He no longer lay around just suffering and enduring. The swelling in his joints subsided and soon he asked for work. He was introduced to the shoe shop and taught leather work. Now he is quite a shoemaker and daily plies his trade.[70]

In spite of the many curiosities of its history - its marginal location, its halting beginnings, and the seeming insignificance of its contribution to medical science – the RCM Ogoja Leprosy Scheme had developed an extensive medical network in Ogoja Province by the time of Independence, offering opportunities for consolidation and expansion of medical, educational, and evangelical services over the years to come. It had become a key Irish missionary enterprise in Nigeria, underpinning the identity of the MMMs, and contributing, at last, to a sense of its innovativeness in the missionary sphere. And ultimately, it was a crucial plank in the attempts of the Catholic Church to highlight and maintain its profile in Nigerian cultural and political life.

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[70] Sr. M.V. Chambers, 'The story of the month: meet my friends', in *The Medical Missionary of Mary*, 21, 9, (1960), pp. 5-8.

Conclusion

In late colonial Ogoja, consigned by circumstance to the ill-defined margins of colonial Nigeria, the rapid institutional expansion of the Roman Catholic Mission proceeded in step with the belated attention paid the region by the colonial state. Alongside the provision of buildings for religious worship and spiritual bureaucracy, a raft of co-operative mission-government welfare services evolved in tandem with a programme of infrastructural provision which loosely networked African and European communities and organisations across the province. The political structures generated by means of the overlay of mission geographies on existing methods of resource management complicated the intricate arbitration to which local ethnicity was subject, and by which it was defined. The interpolation of new interpretive strategies consequent on this missionary engagement, helped to elaborate the bases on which ethnicity was constituted, and gave territorial and linguistic distinctions a novel significance, and a newly absolute constitution.

The historiography of post-1945 Nigeria is dominated by narratives of galloping constitutional change, the growing salience of nationalist politics, and the dizzying process of colonial disengagement ostensibly culminating in Nigerian Independence in October 1960. The entrenchment of ethnic stakes which characterised the political spectacle of mid- and late- twentieth century Nigeria is traced to the political articulations and reactions taking place during this short period between World War Two and Independence. The implications of this for the historiography of Ogoja and the Cross River region can be seen in the work of Sandy Onor, and in the volume on Cross River and Akwa Ibom history edited by Monday Abasiattai, where attempts to integrate and unify the history of the region, its locales, and its people, characterised as ethnicities, predominate, effectively recognising and legitimising dominant models of explication in Nigerian history. The extreme circumstances of the secession of Biafra and the Nigerian Civil War of 1967-70 seem to underline the logic of this mode of writing history and narrating politics in Nigeria. The resulting obeisance to a model centred on explicating postcolonial distress acts to impose a shortsighted and conceptually somewhat limiting teleology on a complex chronology. This thesis attempts to restitute one

component of this complexity.

The complicated interplay between grievances accreted to the nationalist cause and political activities, and the self-reflexive programmes of the colonial state give rise to a contested chronology of late colonial politics in Nigeria. It is generally not disputed that the Richards Constitution of 1946, designed to reconcile the Native Administration system with parliamentary central government, and to signal colonial cognizance of Nigerian desires to take a hand in centralised decision-making, introduced a novel element of regionalism to Nigerian politics, in the form of three Houses of Assembly at Kaduna, Ibadan, and Enugu, or that the consultative shortcomings of its framing stoked the irritation and resentment of politically active Nigerians.[1] The conciliatory overtures of Richards' successor as governor from 1948, J.S. MacPherson, coupled with the emergence of Nnamdi Azikiwe's National Council of Nigeria and the Cameroons as a potent political force, seemed to set in train a cyclical, and more expressly consultative process of constitutional reform, evident in the succession of constitutions dated 1951, 1954 and 1957, which instituted a federal system of regions, provinces and counties and expedited the Nigerianisation of government services and appointments.

As the parameters of mission-government co-operation altered in the years leading up to Nigerian independence, the character of mission services came to seem less distinct from those provided by local, regional and national government bodies. This process is lent a veneer of inevitability both by predominant nationalist accounts of Nigerianisation, and accounts which focus on the decline of mission in post-colonial development politics. It is difficult to determine and explain the shape, scope and resilience of church- and mission-based enterprises in Nigeria through reliance on these historical models alone. In this thesis, I have contended that a focus on the specificities of ideology, bureaucracy and technology of missionary leprosy control, exploded into separable components for analysis of the early years of the RCM Ogoja Leprosy Scheme, and then recomposed in the crucible of rapid Nigerian and global change in the 1950s, challenges the teleologies imposed by nationalist

[1] Coleman, (1971), pp. 271-84.

and development history narratives. This division between ideology, bureaucracy and technology, corresponding here with chapters on spirituality, administration and medicine, enables a dovetailing of this account of a particular and ostensibly marginal service with broader narratives of late colonial development politics, and textures these narratives in a manner which proves vital to understanding Nigeria's encounter with the world at large. Further, it offers a foundation on which future research on the relations between mission and government can contribute to challenging nationalist and development historiographies. With this in mind, I summarise my findings under four headings in the concluding section.

Constructing a field of enquiry for the history of leprosy control

(i) Medical therapies and the development of leprosy services

The course of change and innovation in medical therapy did not in itself completely determine the development and form of leprosy control in most situations. One factor was the issue of cost, which in itself was multi-factorial and composed of notions of responsibility for funding, perceived value in conjunction with politicised development goals, and the administrative upheaval signalled by change. Also, the production and flow of information and innovation itself was constrained by geographical isolation, government policy regarding therapy and subsidy, and the degree to which the capabilities of various leprosy schemes were oriented at different times for the receipt and deployment of novel therapies.

Part of the process of instituting leprosy control in Ogoja Province was the collocation and improvement of epidemiological knowledge and expertise on the area to be covered by the scheme. As has been shown in earlier chapters, systematic knowledge about Ogoja, complicated by poor understanding of the ethnic, linguistic and economic terrain encountered by European colonists, was hampered by scant and weak foundations. Thus, as well as harvesting of scattered notions of disease prevalence, and constructing a decidedly

patchy geography of health and illness, the first medical staff of the RCM Ogoja Leprosy Scheme found themselves engaged, along with colonial administrators, in the often unwitting invention of a distinct type of colonial space. The concrete linking of knowledge about Ogoja to the design and provision of a particular range of services helped undergird new colonial welfare and development agendas in Ogoja Province prior to Independence.

Irish research into tuberculosis control provided an important and timely impetus to Irish missionary leprosy control - the fact that TB persisted as a public health problem in Ireland somewhat later than in much of western Europe meant that significant research into TB chemotherapy continued to attract state funding through the 1950s and 1960s. This had dual ramifications: through the offices of Joe Barnes and Denis Freeman in Ogoja, a new set of experimental TB treatments were introduced into the world of leprosy chemotherapy, with the eventual result that clofazimine, developed by the Irish Medical Research Council project on TB therapy, was standardised for the treatment of leprosy in the early 1960s, and forms an important component of present-day multi-drug therapy for leprosy.

(ii) The politics of administering leprosy control

The oft-repeated notion that leprosy was uniquely, or, at the very least, pre-eminently the preserve of mission agencies is vitally important in understanding the importance of an investigation of missionary leprosy control schemes. Such an investigation enables an understanding of what links the presentation of the later history of these organisations to the chronology outlined in texts such as Ajayi's and Ayandele's on the early impact of missionaries on Nigerian history. The growing links between missionary organisations and government welfare provision and development planning, made explicit in Sir Sydney Phillipson's reports to the Nigerian Government in the late 1940s and early 1950s, was implicit in the control negotiated by missionaries over the provision of leprosy services. As such, leprosy services mark the transition in understandings of the proper role of missionaries in the colonial and imperial enterprise. This also allows a positioning and

examination of the role of BELRA, enabling a more effective assessment of its strategies.

With this in mind, the position of leprosy services in the extension of the missionary role in general medicine must also be examined. In Ogoja, the institutional distinction between leprosy provision and the provision of dispensary, surgical, and maternity and child health services was not always clear. The struggle to clarify and institutionalise these distinctions takes place at a crucial interface between coloniser, colonial agents such as missionaries, and colonial populations.

(iii) African responses to missionary leprosy control

In the rapidly shifting, broadly nationalising politics of post-1945 Nigeria, 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 constitutional structures. This process continually problematised the representation of leprosy control, as issues surrounding leprosy became entangled with local and regional resource politics and priorities.

Underlying the stylised representation of anthropological 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 the Ogoja leprosy control scheme did much to shape the constraints under which the leprosy scheme 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, helped conserve the power of obsolete approaches to leprosy control: in this way, persisting forms in institutional leprosy care, predicated in part on the conservation of investment, received substantial intellectual underpinning from powerful ideas on the social position of the leprosy sufferer.

While it is fair to say that the Catholicism of the missionaries in Ogoja 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 epistemological and ontological slippage surrounding 'leprosy' as a conceptual and physical construct both exacerbate these difficulties and demand a more rigorous approach to their resolution. Any attempt to deal with the range of issues raised must take into account the structure and hierarchy 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 Ogoja were impinged on by issues in Irish ecclesiastical, cultural and medical politics. At the same time, Ogoja was abstracted as an arena for the delineation of appropriate relations between religion and politics in Ireland, while leprosy provided a lens through which knowledge about Ogoja could be focused and recomposed.

(iv) Catholicism and leprosy control

For the MMMs, their early visibility with regard to the colonial administration was mediated and controlled by the mission, itself dominated administratively by priests from St. Patrick's Missionary Society, and their responsibility for medical services was construed and understood within the boundaries conceived by Joe Barnes, the lay Irish male doctor. All the same, the corporate identity evolving among MMMs locally, across Eastern Nigeria and among the broader global MMM community, and the sense of expertise and ownership deriving from the practical experience of deploying medical services, both as medical and administrative staff, gave MMMs strategic leverage and a strong local profile among the communities they served. In short, the centrality of Ogoja both in MMM perceptions of their work and from a point of view of propaganda, coupled with the increasing social and medical complexity of leprosy control schemes in an era which saw the shift from segregation to out-patient treatment and from imperial to global worldviews, makes the RCM Ogoja Leprosy Scheme a powerful index of trends in charity, aid, African politics, and the development and reception of medical technologies and strategies in the period between the end of World War Two and Nigerian independence in 1960.

Consequently, an assessment of the spiritual component of mission, usually seen as tangential to the predominantly instrumentalist accounts of the significance of missionary welfare work in Africa, vitally grounds a thorough understanding of mission and colonialism. Evoking a Catholic mode of engagement with and critique of colonial power

relations, seemingly inconsistent or at odds with bureaucratic or materialist analyses of colonial politics, the analysis I propound seeks to be sensitive to the creation of stakes and identities consequent on religiously mediated understandings of duty, entitlement and ministry.

In order to understand how and why the Catholic Church in Nigeria developed such a strong stake in welfare service delivery, and how it managed to convincingly articulate its stakeholding to a broader political and social constituency, the ways in which religious and lay Catholics, both missionary and Nigerian, understood their work and interpreted it to themselves and others must be examined. To this end, I focused on the language and rhetoric of spirituality, how it guided institutional governance and missionary praxis in the context of leprosy and evangelical work in Ogoja Province, and how it came to suffuse the Irish presence in this part of Nigeria with a particular interpretive and creative social power.

The constitution of African communities and the abstraction of aspects of African life as a form of practical anthropology or colonial demotic grounded administrative responses of colonial and missionary bureaucrat alike. This resulted in a close correlation between the epistemological contours of such a hybrid bureaucratic response, and the elaboration of African political stakes in the colonial politics of health and resources. The careful redescription I have undertaken here of bureaucratic process, under the sign of Catholic social thought, helps to unpick a range of teleological approaches to the history of development in Nigeria, and grounds changes in bureaucratic process and medical politics in its often-overlooked and regularly traduced local specificities.

The bluster of missionary propaganda, keen to portray the magnitude both of the challenges of leprosy in Ogoja and of the generosity of donor and mission response to it, obscured,

though without expressly concealing, the tenuousness of RCM medical beginnings in Ogoja.[2] This tenuousness can be discerned both in relating the Ogoja scheme to Nigeria-wide leprosy control templates and programmes in the immediate aftermath of World War Two, and in Ogoja-based missionary medical responses to local medicines, standard biomedical palliatives for leprosy, and novel pharmaceutical therapies in development from 1940 onwards.

By the mid-1950s, the ever-closer interlinking between Catholic medical missionary praxis as exemplified in the setting of Ogoja Province, and Nigeria- and world-wide leprosy control theory and technique can be seen at the level of development goals and ideals, of epidemiological and information-gathering strategies and structures, and of biomedical and public-health approaches to leprosy in its social setting and biological presentation. This coincidence between missionary and secular approaches to development and leprosy control would seem to portend the obsolescence of an independent Catholic and missionary discourse on issues of development, and presage the absorption and subsumption of Catholic social services, were it not for the intensity of RCM investment in managing its institutions, social networks, and resources, whose rhetorical, bureaucratic and medical concomitants are described in the course of the thesis.

Transformations in the nature of the effective contract between mission and government, altered the context in which Catholic missionary welfare services were provided, and in the case of leprosy control, interacted with fundamental technological and capacity changes to create a complex and, at times, fraught medical politics needing careful negotiation from all parties. Examined from the viewpoint of missionaries, this process offers a new perspective on the processes of decolonisation and the politics of independence in Nigeria.

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[2] C.M. Good, *The Steamer Parish: the Rise and Fall of Missionary Medicine on an African Frontier*, (2004), p. 444 outlines a similar disjuncture between the rhetoric of missionary potency and the local status of missionary enterprise in post-1945 Nyasaland, a hubris which had more calamitous effects on the continued relevance of the Universities' Mission to Central Africa (UMCA) presence in Nyasaland and Malawi than was the case from the RCM in Eastern Nigeria.

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