

**‘Things that Matter’:
Missionaries, Government, and Patients in the
Shaping of Uganda’s Leprosy Settlements,
1927-1951**

Kathleen Vongsathorn
Green Templeton College

Thesis submitted in partial fulfillment of the requirements for the degree of
Doctor of Philosophy in the Faculty of History at the
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Firstly, this thesis explores the ways in which the differing goals, ideologies, and resources of the Protestant CMS and the Catholic FMSA and MHM shaped the formation of and social environment within leprosy settlements in a highly Christianised and denominationally divided Uganda. Secondly, it examines the relationship between the CMS and Franciscan leprosy missions and the government, exploring the cooperation and conflict that their spiritual and medical priorities had upon the social lives of patients within Uganda’s leprosy settlements. Thirdly, this thesis assesses the extent to which missionaries consciously endeavoured to engineer a social environment for leprosy patients within settlements that conformed to their ideal of Christianised, modern African communities, as well the roles that healthy and leprous Ugandans chose to play in response to these attempts at social engineering. Missionaries and Ugandan leprosy patients had different priorities, but far from being passive receptacles of the ‘civilising’ mission, most leprosy patients were active agents in pursuing their own medical, social, and economic priorities through life in the settlements.

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Long Abstract

This thesis examines the role of missionaries, the colonial government, and leprosy patients in the formation of leprosy settlements in Uganda, from the first inception of the settlements in 1927, until 1951 when the nature of leprosy control in Uganda changed, with the government appointment of a Protectorate leprologist and the creation of more treatment centres. It focuses on four leprosy settlements opened between 1930 and 1934 by the Anglican Church Missionary Society (CMS) and the British and Irish Catholic Franciscan Missionary Sisters for Africa (FMSA) and Mill Hill Mission (MHM).

The CMS founded Uganda’s first large-scale in-patient leprosy settlements at Kumi in eastern Uganda and Lake Bunyonyi in southwest Uganda in 1930 and 1931, staffing them with two resident female missionaries and a visiting doctor. By the 1940s, these settlements had grown to 1000 and 700 in-patients respectively. The FMSA founded Uganda’s next two leprosy settlements in 1932, at Nyenga, and 1934, at Buluba, both in central Uganda. The settlements were staffed by several resident FMSA Sisters and one part-time MHM chaplain, and grew more slowly than their CMS predecessors, to a size of 250 and 270 in-patients respectively in the 1940s.

This thesis explores the ways in which the differing goals, ideologies, and resources of the Protestant CMS and the Catholic FMSA and MHM shaped the formation of and social environment within leprosy settlements in a highly Christianised and denominationally

divided Uganda. Secondly, it examines the relationship between the CMS and Franciscan leprosy missions and the government, exploring the cooperation and conflict that their spiritual and medical priorities had upon the social lives of patients within Uganda's leprosy settlements. Thirdly, this thesis assesses the extent to which missionaries consciously endeavoured to engineer a social environment for leprosy patients within settlements that conformed to their ideal of Christianised, modern African communities, as well the roles that healthy and leprous Ugandans chose to play in response to these attempts at social engineering. Missionaries and Ugandan leprosy patients had different priorities, but far from being passive receptacles of the 'civilising' mission, most leprosy patients were active agents in pursuing their own medical, social, and economic priorities through life in the settlements.

This thesis is structured in six chapters, the first of which contrasts the medical mission ideologies of the CMS with those of the FMSA and MHM with a view towards understanding their differing approaches to leprosy settlement in Uganda in the context of competition for Christian converts. It offers a history of the growth of Christian mission in Uganda, the development of medical mission, and the contrasting ideologies of medicine and leprosy held by Catholic and Protestant missionaries. Although medical mission has long been an area of interest for historians, no scholarly works have ever compared the ideologies and resources that differentially affected Catholics and Protestants in their medical mission to Africa. In this first chapter, I address this gap by using mission-run leprosy settlements as a lens through which to examine the effects that the differing religious and social ideologies of these missionaries had on the character of medical mission, and on the experiences of the Ugandans who lived in leprosy settlements. Uganda provides a particularly significant backdrop for such an exploration, as the relatively small number of mission societies present before the 1940s contributed to an intense competition between Protestant and Catholic missions and their converts, the aftermath of which is still felt in Uganda today.

The second chapter builds on this discussion of the European influences that shaped leprosy settlements in Uganda by exploring the involvement of Uganda's colonial government in the treatment of leprosy. It assesses relationships between missionaries and government officials, based on their national and religious affiliation, at a local and central level; explores the similar ideologies and goals of these individuals; and discusses the ways that these similarities shaped the provision of a system of leprosy treatment in Uganda that was collaborative and yet extremely limited in its scope and effectiveness by the standards of public health. In its exploration of the cooperation between missionaries and colonial government officials over the treatment of leprosy in Uganda, this thesis offers a new perspective on relations between the secular and religious in the colonial era. Early historiography on medicine in British colonial Africa suggests that colonial government and missionary medicine occupied two relatively distinct spheres, and that government officials viewed medical missionaries with suspicion and distrust. Contrary to this paradigm, this thesis suggests that missionaries and colonial government officials collaborated extensively and amicably in the treatment of leprosy in Uganda. The mutual social and cultural priorities of missionaries and government administrators led to a system of isolated, in-patient leprosy care that was limited in scope and reflective not of a goal for the public health of Uganda, but rather a vision for the future of Uganda as a 'civilised' and Christian country.

The third chapter explores the enactment of the mission goal for a 'civilised' and Christian Uganda through their attempts to create 'model villages' and model lives within leprosy settlements. The greatest hope of Uganda's leprosy missionaries was that the leprosy sufferers under their care would transcend their 'primitive' Ugandan backgrounds to lead model lives under the healthy, civilised, and Christian influence of the settlements' European and Ugandan staff. This chapter explores the missionaries' attempts to enact that goal

through an analysis of each settlement's design, from its site, layout, and construction to the social, political, and economic organisation and facilities that the missionaries provided.

The fourth chapter provides an even closer analysis of mission attempts to socially engineer lives within Ugandan communities by focusing on children within leprosy settlements, who far more successfully embodied the model of modernised and Christian leprosy patients than their adult counterparts. This role was so successfully played because in their youth and their separation from families, children were more easily influenced by missionaries' endeavours to 'civilise' and evangelise. There is very little historical literature on children in Africa; most of it is focused either on child labour, or on the institutions in which children were educated. This chapter examines the special role that children had in the eyes of missionaries as vulnerable and impressionable individuals, and the ways that life within a leprosy settlement changed the social experiences of these children.

The final two chapters of the thesis bring out the perspective of the patients who lived in Uganda's leprosy settlements. The fifth chapter begins by introducing the residents of Uganda's leprosy settlements, offering such background information as their age, gender, ethnicity, religion, and medical condition. It then goes on to discuss the reasons that leprosy patients entered the settlements, highlighting the range of actors who were involved in these decisions. It concludes with an exploration of how these actors, including relatives, local authorities, and chiefs, remained involved in the lives of leprosy in-patients and the functioning of the leprosy settlements.

The sixth chapter of the thesis assesses interactions between Ugandan leprosy patients, European missionaries, and other settlement staff, exploring the negotiations upon which the leprosy settlements were built. It discusses patients' physical and emotional experiences of leprosy in the settlements, offering a counter-narrative to the missionary and government ideals of 'civilisation', Christianity, and biomedicine that are described in the

first four chapters of the thesis. It then explores some of the day to day compromises and arguments between patients and missionaries over their lifestyle and priorities. The leprosy settlements had a small staff and even smaller missionary presence, and as such, Uganda's leprosy patients had great power to negotiate the shaping of their own lives, even within the confines of the settlements. The chapter then concludes with a discussion of how and why patients came to leave the leprosy settlements.

Although leprosy has been an area of great interest for historians of medicine, the question of the social environment within leprosy settlements, and the differential influence that Catholic *and* Protestant missionaries exerted upon this environment in Africa, has not been thoroughly examined. Drawing on a wealth of new sources, this thesis aims to fill a gap in the study of leprosy institutions by focusing on the religious and social experiences of Ugandan leprosy patients, and the ways that the involvement of Catholic and Protestant missionaries and government officials impacted upon these experiences.

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List of Abbreviations

BELRA	British Empire Leprosy Relief Association
BH	Bishop's House
CMS	Church Missionary Society
DC	District Commissioner
DMO	District Medical Officer
DMS	Director of Medical Service
DMSS	Director of Medical and Sanitary Services
FMSA	Franciscan Missionary Sisters for Africa
JDA	Jinja District Archives
KDA	Kabale District Archives
MHM	Mill Hill Mission
PC	Provincial Commissioner
PMO	Provincial Medical Officer
RCA	Rubaga Cathedral Archives
SDA	Soroti District Archives
UGA	Uganda National Archives
UKNA	United Kingdom National Archives

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Introduction

There was a fine school, playing fields, completely equipped hospital with several wards, native crops growing in abundance, goats, sheep, etc., in fact all the amenities of native village life. And the lepers themselves—they were forgetting their terrible affliction under the kindly ministrations of Miss Langley, and actually they were living their usual normal village life, but at the same time they were apart from the rest of the world...¹

The Anglican Church Missionary Society (CMS) and the Franciscan Missionary Sisters for Africa (FMSA) and Mill Hill Mission (MHM) founded four large-scale in-patient leprosy settlements in Uganda between 1927 and 1934. This thesis examines the role of missionaries, the colonial government, and leprosy patients in the formation of these Ugandan leprosy settlements.

The study begins in 1927 when plans for the founding of the first institution for the care and treatment of leprosy patients in Uganda were conceived, and ends in 1951, when the nature of leprosy control in Uganda changed, with the government appointment of a Protectorate leprologist and the creation of more treatment centres. Two of the settlements were run by the CMS, housing more than 700 patients and their healthy family members: the Kumi Children's Home and Ongino Settlement (opened in 1930) and the Lake Bunyonyi Settlement (opened in 1931). The other two settlements, opened in 1932 and 1934, at Nyenga and Buluba respectively, housed about 250 patients each and were run by the FMSA and MHM (see Map 1).

Firstly, this thesis explores the ways in which the differing goals, ideologies, and resources of Protestant and Catholic missionaries shaped the formation of and social environment within leprosy settlements in a highly Christianised and denominationally divided Uganda. In so doing, this research is the first attempt to compare the distinct approaches that Catholics and Protestants brought to medical mission in Africa.

¹ 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.



Map 1: Location of Uganda's Leprosy Settlements (red stars)

Secondly, the thesis examines the relationship between the Catholic and Protestant leprosy missions and the government, exploring the cooperation and conflict that their spiritual and medical priorities had upon the social lives of patients within Uganda's leprosy settlements. Contrary to the historiography that suggests colonial government and missionary medicine occupied two relatively distinct spheres, my research suggests that missionaries and colonial government officials collaborated extensively and amicably in the treatment of leprosy in Uganda.

Thirdly, this thesis assesses the extent to which missionaries consciously endeavoured to engineer a social environment for leprosy patients within the settlements that conformed to their ideal of Christianised, modern African communities, as well the roles that healthy and leprous Ugandans chose to play in response to these attempts at social engineering.

Missionaries and Ugandan leprosy patients had different priorities, but far from being passive receptacles of the ‘civilising’ mission, most leprosy patients were active agents in pursuing their own medical, social, and economic priorities. The description of the CMS Lake Bunyonyi leprosy settlement with which the introduction opens is typical of the value that missionaries and government officials placed on the leprosy settlement as a place in which sufferers could live happy, useful, and ‘civilised’ lives. This thesis examines these ideals, not only from the perspective of the Europeans who maintained the settlements, but also from the perspective of the Ugandans who made the settlements a reality.

Leprosy in Historical Context

Popular stereotypes about leprosy suggest that it is a horrific, disfiguring, highly contagious disease that is and always has been universally stigmatised. In reality, however, leprosy is mildly contagious, grossly disfigures only a minority of its victims, and has been perceived with tolerance and acceptance by many, from medieval Europe to contemporary Africa. Attitudes towards leprosy have often been mixed, and this section outlines a variety of perspectives on leprosy, all of which impacted the way that leprosy was perceived and treated in and around Uganda’s mission leprosy settlements.

Leprosy in Christian History

Leprosy has a long history of Christian significance, both negative and positive, which has influenced the ways in which the disease and its sufferers were perceived and dealt with in the Christian world over the millennia. The Christian symbolism of leprosy originates with the Bible: in the Old Testament, leprosy was a punishment from God for ritual transgressions, and denoted a religiously unclean individual who was thereby ostracised by society.² The New Testament, on the other hand, carried a more positive image of the

² As early as 1911, doctors began questioning whether the Hebrew word referring to these unclean ‘lepers’ had been mistranslated, with such illnesses as psoriasis, skin cancer, and yaws being a more accurate diagnosis

leprosy sufferer, with Christ setting a compassionate example by healing and embracing leprosy sufferers, and exhorting his followers to ‘cleanse the lepers’.³ Perceptions of leprosy were accordingly mixed in medieval Europe, when leprosy was endemic, with leprosy sufferers on the one hand cast as sinners and on the other hand as chosen by God to pursue a special religious calling.⁴

When the missionaries who founded and supervised Uganda’s leprosy settlements arrived in Uganda in the early twentieth century, it was with certain preconceptions about leprosy and its sufferers. Leprosy had disappeared from most parts of Europe by the seventeenth century, so when the British again encountered leprosy in the tropical world, they fashioned new ideas about the disease, with four sources: the Bible, history, attitudes towards disfigurement, and biomedicine.

At a time when leprosy was extremely rare in Great Britain, the Bible provided many people’s first point of reference for leprosy.⁵ In 1911, a dermatologist wrote that:

There are many reasons for believing that the extraordinary fear of leprosy, which is so universally present today and which has worked hardship and misery to so many unfortunate victims of the disease, is a result, in part at least, of the influence of the biblical references to “leprosy.” These accounts, when interpreted literally, depict the condition as most terrible, and belief in them is widespread since the Bible, accepted by millions as a revelation of the divine, is the most read book in the world.⁶

In 1916, a London lawyer defending clients charged with bringing a leprosy patient to a lodging house and conspiring to conceal his disease stated that ‘one’s horror of leprosy arose at the earliest age, for as children they learned from the Bible to regard a leper as a horrible person; and there was, therefore, a danger of prejudice against the defendants’.⁷ The jury did

based on the symptoms described. E.L. McEwen, ‘The Leprosy of the Bible in Its Medical Aspect’, *The Biblical World*, 38.3 (September 1911), 194; M. Douglas, *Leviticus as Literature* (Oxford, 2009), 183-4.

³ Matthew 10:8

⁴ F.-O. Touati, ‘Les Léproseries aux XII^{ème} et XIII^{ème} siècles, Lieux de Conversion?’, in N. Bériou and F.-O. Touati (eds.), *Voluntate dei Leprosus: les Lépreux entre Conversion et Exclusion aux XII^{ème} et XIII^{ème} Siècles* (Spoleto, 1991), 1-32.

⁵ Z. Gussow and G. Tracy, ‘The Use of Archival Materials in the Analysis and Interpretation of Field Data’, *American Anthropologist*, 73.3 (1971), 702.

⁶ McEwen, ‘The Leprosy of the Bible’, 194.

⁷ ‘High Court of Justice’, *The Times*, 17 May 1916.

indeed find the defendants guilty of conspiring to bring a 'leper' into a lodging house, and the judge had to overturn their verdict because it had no legal grounds.

As influential as the biblical treatment of leprosy was to the Christian missionaries' beliefs about leprosy, they were also influenced by the prevailing notion that disfiguration necessarily resulted in stigma. As the medical missionary Stanley Browne wrote:

It would be quite wrong, and historically unjustifiable, to attribute wholly to the influence of biblical and Christian teaching the widespread stigma attached to leprosy...The victim of leprosy often does present a repulsive, even nauseating appearance, a travesty of the human form. In many non-Christian lands and non-Christian civilizations, there exist an innate dread and fear of true leprosy.⁸

Many British sufferers of skin disease felt great shame about their disfiguration, often taking night jobs and visiting the doctor only in the evenings.⁹ Missionaries expected leprosy sufferers in Uganda to feel the same shame, for as CMS nurse Langley wrote, leprosy sufferers were 'perhaps the most repulsive of all men'.¹⁰ The physical disfiguration that could accompany leprosy was severe enough to form an assumption of universal stigma, without reference to historical or biblical tradition.

The doctors and nurses who were involved in the treatment of leprosy patients in Uganda were also informed by a growing body of medical and scientific research on leprosy. As leprosy was believed to be spread by prolonged physical contact among people of 'a low stage of civilization, with the accompanying grave hygienic deficiencies', education about hygiene and the contagiousness of leprosy was an important means of prophylaxis.¹¹ If leprosy patients did not face stigma and neglect, then it was thought to be the result of 'primitive' ignorance, and in educating Ugandans about the contagion of leprosy, missionaries believed they were providing a biomedical and moral service.¹²

⁸ S. Browne, *Leprosy in the Bible* (London, 1970), 17.

⁹ B. Russell (ed.), *St. John's Hospital for Diseases of the Skin* (Edinburgh, 1963), 10.

¹⁰ R. Langley, 'Cleanse the Lepers', *Mission Hospital*, 431 (December 1933), 312; R. Langley, 'The Hospital from a New Worker's Point of View', *Ruanda Notes*, 34 (1930), 24.

¹¹ L. Rogers and E. Muir, *Leprosy*, 1st edn (London, 1925), 51.

¹² Langley, 'Cleanse the Lepers', 313.

Leprosy in Uganda

Perceptions of leprosy in Uganda, which varied widely across the ethnic groups, underwent rapid transitions after missionaries began leprosy work in 1927. Yet because very little documentation about leprosy precedes the foundation of leprosy treatment centres, it is difficult to formulate a precise understanding of the ways in which the peoples of Uganda perceived leprosy and its sufferers before 1927, much less in the pre-colonial era. In an effort to overcome this dearth of pre-colonial and early colonial written sources in order to reconstruct a picture of Ugandan attitudes towards leprosy before the advent of biomedical leprosy education and leprosy settlements, this section will integrate literature on pre-colonial concepts of health and healing in the Great Lakes Region with mission and government records from the earliest years of leprosy work, colonial and postcolonial ethnographies, and contemporary interviews with elderly former leprosy patients. In particular it will focus on the four ethnic groups that represented the majority of each leprosy settlement's patients: the Bakiga at Lake Bunyonyi, the Iteso at Kumi and Ongino, the Basoga at Buluba, and the Baganda at Nyenga.

Before medical missionaries arrived in Kigezi in the 1920s, the Bakiga of south-western Uganda recognised leprosy, or *ebibembe*, as a distinct disease, but did not stigmatise its sufferers. One CMS doctor wrote in 1931 that:

The native knowledge of the disease is surprisingly exact...They show in their diagnosis a clinical acumen which is quite remarkable. I have had cases brought to me as leprosy in the earliest stages which I would have hesitated to accept as such, until a positive scraping from the nose revealed the bacillus leprae, and proved these primitive diagnosticians correct.¹³

The Bakiga did not perceive leprosy as physically contagious, but rather as a supernatural penalty for breaking a ritual proscription or taboo, such as stepping on a human grave or

¹³ A.C.S. Smith, 'Leprosy in Kigezi, Uganda Protectorate', *Mission Hospital*, 35.407 (1931), 312.

breastfeeding from a woman who had given birth outside of marriage.¹⁴ For the Bakiga, illness and misfortune could come in three ways: through the malevolence of a spirit; through the High God, who ordered the universe; or through a human intermediary, generally a witch or sorcerer calling upon a spirit.¹⁵ Leprosy, specifically, was not attributed to witchcraft, but rather to the spite of spirits or a deity.¹⁶ Malevolent spirits, usually ghosts, generally directed their rancour towards their living relatives on a whim, without reference to their behaviour or character. Leprosy was not, then, a punishment for any conscious transgression, and since it was neither contagious nor associated with moral flaws, there was no blame or fear attached to the leprosy sufferer, nor any need for the segregation of leprosy sufferers. A 1950 survey of leprosy in Kigezi indicated that only four percent of Bakiga leprosy sufferers lived in a separate hut, apart from their relatives.¹⁷ The remaining 96 percent were ‘allowed the freest intercourse with the rest of the community’, and the marriage of leprous men and ‘untainted’ women was common.¹⁸ This begs the question of why, when most leprosy sufferers were accepted by their families and communities, a small proportion were neglected or outcast.

The Bakiga response towards leprosy sufferers can be partially understood through studies of health and healing in the pre-colonial Great Lakes region of East Africa, which highlight the perceived link between prosperity and health.¹⁹ In early colonial Kigezi, this link was quite literal: the terrace farming undertaken by the Bakiga was a labour-intensive process, and in order to contribute to family and society, the majority of individuals needed to

¹⁴ M.M. Edel, *The Chiga of Western Uganda* (New York, 1957), 124; P. Ngologoza, *Kigezi and its People* (Kampala, 1998), 19-20; Interview with John, 11 August 2011.

¹⁵ Edel, *The Chiga of Western Uganda*, 129-72; Leprosy Mission Archives, Brentford, England (Leprosy Mission), 118/16, Minutes from Teso Leprosy Sub-Committee, 2 May 1929; D. Schoenbrun, *A Green Place, A Good Place: Agrarian Change, Gender, and Social Identity in the Great Lakes Region to the 15th Century* (Portsmouth, 1998), 198.

¹⁶ Edel, *The Chiga of Western Uganda*, 130.

¹⁷ J.R. Innes, ‘Leprosy in Uganda: A Survey in the Kigezi District’, *East African Medical Journal*, 27.7 (1950), 281.

¹⁸ Innes, ‘Leprosy in Uganda’, 281.

¹⁹ Schoenbrun, *A Green Place, A Good Place*, 108; N. Kodesh, *Beyond the Royal Gaze: Clanship and Public Healing in Buganda* (Charlottesville, 2010), 20.

be able-bodied enough to cultivate.²⁰ Societal worth was not judged by an individual's physical appearance, as was sometimes the case in Britain, where signs of disfiguration on the skin detracted from one's personhood.²¹ Rather, it was judged by one's ability to contribute to social prosperity, which was decreased by physical debility. Disability has a long history of complicating and transforming economic and kinship relations, and as anthropologist Julie Livingston writes, 'Certain bodily states pose problems. Debility is one such state because it troubles, mobilizes, and intensifies social relations'.²² A CMS nurse in Kigezi noted:

The leper in Africa is not an outcast *because* he is a leper, but rather as a result of his inability to care for himself in the later terrible stages of the fell disease. For who is going to make time or spend hard-earned cents on feeding or caring for the leper? He must struggle on as best he can until his strength fails him entirely, and he is pushed in to some dark corner and forgotten.²³

Distortions of the skin, which were so well recognised by the Bakiga as the early symptoms of *ebibembe*, were commonplace in Kigezi, where many suffered from ailments that affected physical appearance, such as yaws. It was not until 1967 that a written record of the Bakiga considering leprosy sufferers to be ugly appears.²⁴ Debility, which affected only a minority of leprosy sufferers, was far less common and far more problematic. The Bakiga cared for the elderly or temporarily ill with support and respect, but when faced with the sufferer of a chronic illness that was disabling but not deadly, the response was neglect, which was also a frequent response to those with other physical disabilities.²⁵

The Iteso also did not fear or stigmatise those who suffered from the symptoms of leprosy, and in fact did not recognise leprosy as one distinct disease before CMS missionaries founded leprosy settlements at Kumi and Ongino. This absence of stigma makes sense given

²⁰ Edel, *The Chiga of Western Uganda*, 79-80.

²¹ C. Benthien, *Skin: On the Cultural Border Between Self and the World* (New York, 2002), 100; E. Goffman, *Stigma: Notes on the Management of Spoiled Identity* (New Jersey, 1963), 64-8.

²² R. Rapp and F. Ginsburg, 'Enabling Disability: Rewriting Kinship, Reimagining Citizenship', *Public Culture*, 13.3 (2001), 533-56; J. Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington, 2005), 3.

²³ Langley, 'Cleanse the Lepers', 313.

²⁴ P. Ngologozo, *Kigezi and its People* (Kampala, 1998), 70.

²⁵ Edel, *The Chiga of Western Uganda*, 33, 130, 144.

that for the Iteso blame for misfortune was seen as external and not internal, and ideas of personhood were defined not by body image but rather by actions and emotions.²⁶ In their earliest stages, leprosy lesions were considered to be birthmarks, and as the disease advanced, it was ascribed to other ailments.²⁷ Leprosy was called by a variety of names, depending upon the visible symptoms present in the patient. *Atapon na tom* referred to people with elephant-like features such as large ears and facial disfigurements, while *Atapon na Risa* referred to the patched and spotted skin, resembling a leopard. A number of other names referred to people who had lost fingers or toes, and other diseases that affected the skin were also conflated with leprosy, including syphilis and scabies.²⁸ A 1979 survey done in Teso indicated that most locals with parents old enough to remember the opening of the district's first leprosy centre believed that leprosy was first brought to the area when missionaries began importing leprosy patients for treatment at the leprosy settlements.²⁹ CMS Dr. Wiggins wrote in 1928 that 'the people ignore leprosy entirely and they have no fear of it'.³⁰ The variety of diseases or afflictions to which leprosy's symptoms were ascribed are also reflected in the variety of causes supposed for leprosy's spread, including heredity, a family curse, or sorcery from a leprosy sufferer who had been wronged or killed.³¹

Reconstructing the conceptualisation of leprosy among the Basoga before the FMSA missionaries began leprosy work at Buluba is an especially difficult prospect, not least because perceptions of the disease seem to have been ambiguous at the time. The Basoga recognised leprosy as a distinct disease, *ekigenge*, and feared it enough that many supposedly

²⁶ I. Karp, 'Person, Notions of', in J. Middleton (ed.), *Encyclopedia of Africa South of the Sahara*, vol. 3 (New York, 1997), 393.

²⁷ Rubaga Cathedral Archives, Kampala (RCA), Kumi Annual Report, 1949.

²⁸ M. Mallinga, 'Attitudes Towards Leprosy in Kumi District' (Makerere University, BA dissertation, 1980), 38-9.

²⁹ Mallinga, 'Attitudes Towards Leprosy in Kumi District', 41.

³⁰ Leprosy Mission, 118/16, Wiggins, 'The Proposed Anti-Leprosy Campaign in Teso, Uganda', May 1928.

³¹ Interview with Michael, 6 July 2010; Interview with Lawrence, 6 July 2010; Interview with John, 7 July 2010; Mallinga, 'Attitudes Towards Leprosy in Kumi District', 47, 52.

cooperated when a British colonial officer introduced the same system of leprosy segregation that occurred in neighbouring Buganda:

It [segregation] was only brought in very gradually and was entirely a voluntary system but being so it “took root” and is now almost universally adopted in Busoga. When a person is found to have leprosy, a hut is built outside the village...to which the leper goes... Food is taken to the leper, who is visited by the “conjugal partner” during the early stages or first period of the disease only.³²

The extent of segregation before this adaptation, which was recounted in 1927, is unclear.

However, interviews with men who contracted leprosy as children in Busoga in the 1940s indicate that while they faced stigma among their village playmates once their illness became visible, they did not personally experience physical isolation from their relatives until they entered the leprosy settlement. As one former patient recalled, ‘You no longer fit in society, you no longer share a meal with others. You are isolated and fed elsewhere... [but] I did not experience many problems since I was a child and would not traverse the village’.³³ Leprosy did affect social relationships, but it was not perceived as threatening or disturbing enough to reorient kinship ties.

In interviews, the most common explanation offered for leprosy’s causation in the old days was witchcraft, which is supported by the general Basoga belief that any illness, death, or misfortune was most likely the result of witchcraft.³⁴ Witchcraft as the origin of leprosy does not explain the fear of the leprosy sufferer, but as Christianity spread through Busoga, some people came also to believe that leprosy was a punishment from God.³⁵ Moreover, leprosy was associated with physical disfiguration, which is highlighted by two Kisoga proverbs about leprosy, translated as: ‘He is suffering like a leper picking a needle’, which refers to the suffering caused by disability, and ‘Do not fold your fingers in the presence of a

³² Jinja District Archive, Jinja, Uganda (JDA), Medical Leprosy, Letter from Elliot to Chief Secretary, Entebbe, 1927.

³³ Interview with Vincent, 28 April 2010 (Buluba, 1944, age 18).

³⁴ Interview with Yoana and Vincent, 15 August 2011; Interview with Veronica, 21 April 2010; Cultural Research Centre, *Witchcraft, Divination, and Healing among the Basoga* (Kisubi, 2003), 13.

³⁵ Interview with Yoana and Vincent, 15 August 2011.

leper (for he may think you are mocking him)'.³⁶ It does not necessarily follow that disfiguration would be a cause for fear or disgust, but in their explanations of why others had feared their leprosy, former Basoga leprosy patients said, 'I think people feared leprosy because it is incurable and its effects are disastrous like losing some body parts like limbs' and 'people fear leprosy because you are no longer normal, without fingers and toes'.³⁷

Before and after the foundation of the leprosy settlement at Nyenga, the Baganda reportedly 'know leprosy well, are afraid of it, and extend the usual social ostracism to lepers'.³⁸ Leprosy was one of the most feared illnesses in Buganda, and it carried with it a stigma so extreme that leprosy sufferers were reportedly driven from their villages, a fact that is speculatively borne out by the uncommonly low incidence of leprosy in Buganda, as compared to its neighbouring districts.³⁹ A comprehensive survey of leprosy in Uganda in 1948 showed that approximately 0.27 percent of Bagandans had leprosy, whereas two to fifteen percent of the people examined in most other parts of Uganda had leprosy.⁴⁰ The segregation of various misfits was commonplace in Buganda, where a 1960s survey showed that ten percent of all Bagandan homesteads housed individuals rejected by their communities because of old age, epilepsy, mental illness, leprosy, or tuberculosis.⁴¹ Leprosy patients could be quite literally cast out of their families, losing their second names when expelled; no one would inherit from a leper or allow his or her burial near a homestead, for fear of leprosy, which was believed to be highly contagious, though through spirits rather than bacteria.⁴² Luganda proverbs concerning leprosy show a preoccupation with the physical appearance of a leprosy patient; of seven proverbs, four concern the loss of fingers, one the effects of

³⁶ Cultural Research Centre, *Ensambo Dh'Abasoga (Kisoga Proverbs)* (Kisubi, 2009), Proverbs 11 and 17.

³⁷ Interview with Yoana and Vincent, 15 August 2011; Interview with Tom, 22 April 2010.

³⁸ Uganda National Archives, Entebbe, Uganda (UGA), J6/25I, Innes Report 1.

³⁹ J. Iliffe, *The African Poor* (Cambridge, 1987), 216.

⁴⁰ UGA, J6/25I, Innes Report 12.

⁴¹ Iliffe, *The African Poor*, 153.

⁴² J. Orley, *Culture and Mental Illness* (Nairobi, 1970), 38-9, 26.

leprosy on the skin, and another the overall disfigured appearance of a 'leper'.⁴³

Furthermore, anyone suffering from a skin disease was feared as a possible leprosy sufferer, which indicates that leprosy was at least partially feared because of the visible disfiguration that it caused.

Buganda's pre-colonial residents shared the same belief in the interlinked nature of prosperity and social health as the Bakiga, which could suggest that in pre-colonial centuries attitudes towards leprosy did not vary so widely in the Great Lakes region.⁴⁴ In searching for the reason behind a divergence in attitudes towards leprosy between the Bakiga and Baganda, these attitudes being further opposed to each other than any of the other ethnic groups under study, one possible explanation lies in agricultural shifts that took place in the region in the second millennium. The shift from various labour-intensive subsistence activities to intensive banana cultivation occurred in Buganda sometime between 1000 A.D. and 1500 A.D., and with this shift came the possibility of creating a food surplus.⁴⁵ This surplus allowed the creation of a hierarchical system in Buganda that relied on different kinds of labour, not just intensive subsistence agriculture.⁴⁶ Unlike in Kigezi, where intensive agriculture produced a relatively low yield and bananas could not be grown, in Buganda a person's contribution to social wealth was not necessarily predicated upon their able body. Judgement of a person's value could, however, be premised upon the appearance of an individual, as demonstrated by the links between leprosy, stigma, and physical appearance in Bagandan proverbs and ethnographies. A person's value and identity might also have relied upon concepts of health: *chronic* disease was an important factor in influencing suicides.⁴⁷

However in spite of the wealth of documentation asserting leprosy's ultimate stigmatisation in Buganda, interviews with Baganda leprosy patients have told a different

⁴³ F. Walser, *Luganda Proverbs* (Berlin, 1982).

⁴⁴ Kodesh, *Beyond the Royal Gaze*, 95-6.

⁴⁵ H. Hanson, *Landed Obligation: The Practice of Power in Buganda* (Portsmouth, 2003), 28.

⁴⁶ R. Reid, *Political Power in Pre-Colonial Buganda* (Oxford, 2002), 23.

⁴⁷ Orley, *Culture and Mental Illness*, 39.

story. Contracting leprosy was not always followed by expulsion from the family, as one former leprosy patient described: ‘Whether those neighbours loved me or not, for us we were in our home and I was not going to their homes. My people loved me, I was their child’.⁴⁸ As Erving Goffman points out, stigma is often associated with visibility, but on a continuum between private and public life, for while strangers might be put off by a disfigured appearance, family members would not necessarily feel the same.⁴⁹ The same doctor who reported the ‘usual social ostracism’ of leprosy sufferers in Buganda also allowed that:

Most of them claim that in the past they segregated cases of leprosy and dealt with them fiercely or strictly. However that may be, I have not found strict village segregation anywhere. The nearest to it was in the Sese Islands. Most tribes do little or nothing, and in all tribes there is a complete failure to realise the extreme danger to children living in close contact with cases of leprosy.⁵⁰

Thus while evidence indicates that the Baganda feared and stigmatised leprosy more than the other three ethnic groups that hosted mission leprosy settlements, even in Buganda, stigma and isolation did not necessarily follow the contraction of leprosy.

Literature Survey

The history of Africa is a dynamic field of study, and within it lie many strands and sub-fields of research. One such field, with which this thesis engages, is colonial medicine, as provided by government, missionaries, and Africans. Another such field is Ugandan history, and in particular this thesis adds to the growing body of local histories of Uganda, many parts of which have been peripheral to historical scholarship in the region in recent decades.

One of the broadest avenues of research into the history of medicine in Africa has been the use of biomedicine as a form of, or vehicle for, the social and political control of Africans. Megan Vaughan has demonstrated not only that colonial power struggles and

⁴⁸ Interview with Doreen, 30 April 2010.

⁴⁹ Goffman, *Stigma*, 68-9.

⁵⁰ UGA, J6/25I, Innes Report 12.

priorities can be glimpsed through the history of medicine, but also that medicine was crucial to the formation of the colonial and European discourse about Africans.⁵¹ Shula Marks echoes this sentiment, highlighting medicine's potential as a tool through which to examine the power and limitations of colonialism.⁵² This thesis engages with these debates most specifically through its analysis of government and missionary priorities for involvement in medicine.

Early historiography on medicine in British colonial Africa suggests that government medicine was more intrusive and controlling than missionary medicine, and moreover that government officials viewed medical missionaries with suspicion and distrust. Colonial government medicine is characterised as more dehumanising than mission medicine, with Africa serving as a living laboratory for biomedical research.⁵³ Colonial governments are often portrayed as concerned with the public health of Africans only insofar as it meant a productive labour force and limiting risk of disease transmission to Europeans.⁵⁴ In short, it was colonial governments that were supposedly most likely to use medicine as a coercive expression of colonial power.

Medical missionaries, on the other hand, are usually presented as concerned with the physical and spiritual welfare of African patients as individuals, rather than as potential sources of labour. According to some historians, missionaries associated sin with the illness of individual Africans, and conversely, the regained physical health of African patients with

⁵¹ M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, 1991); M. Vaughan, 'Healing and Curing: Issues in the Social History and Anthropology of Medicine in Africa', *Social History of Medicine*, 7.2 (1994), 283-95.

⁵² S. Marks, 'What is Colonial about Colonial Medicine? And What has Happened to Imperialism and Health?', *Social History of Medicine*, 10.2 (1997), 215.

⁵³ Vaughan, *Curing Their Ills*, 37, 49-53; H. Tilley, *Africa as a Living Laboratory: Empire, Development, and the Problem of Scientific Knowledge, 1870-1950* (Chicago, 2011).

⁵⁴ For example: J. Comaroff, 'The Diseased Heart of Africa', in S. Lindenbaum and M. Lock (eds.), *Knowledge, Power and Practice* (Berkeley, 1993), 305-24; M. Lyons, *The Colonial Disease: A Social History of Sleeping Sickness in Northern Zaire, 1900-1940* (Cambridge, 1992), 69; R. Packard, 'The Invention of the 'Tropical Worker': Medical Research and the Quest for Central African Labor on the South African Gold Mines, 1903-36', *Journal of African History*, 34.2 (1993), 271-92; Vaughan, *Curing Their Ills*, 29-53.

spiritual transformation.⁵⁵ This stark differentiation between the healthy and evangelised missionary and the sick and ‘primitive’ African is typical of some of the foundational mission histories of Africa. In *Revelation and Revolution*, for example, the Comaroffs discuss southern African colonial history as an encounter between two monolithic and discrete cultures, British and Tswana.⁵⁶ Their discussion of the hybrid culture that was created through interaction between missionaries and Tswana lays an important foundation for later mission history, but their placement of Africans and Europeans in cultural opposition diminishes the potential for understanding the flexibility that missionaries and Africans brought to their sustained interactions.⁵⁷

In colonial Uganda there is no evidence to suggest that leprosy missionaries believed sin to be in any way responsible for, or related to, a Ugandan’s contraction of leprosy, though accounts attributing leprosy to ignorance and uncleanness are plentiful. Rather, missionaries were full of admiration for many of their leprosy patients, believing even that some of them had a depth and sincerity of Christian faith that they as Britons could only aspire to.⁵⁸ Certainly the missionaries and leprosy patients who interacted in Uganda’s leprosy settlements had different priorities and ideologies, but each was open to adaptation in their pursuit for health, prosperity, civilisation, and Christianity, even if they valued these goals very differently. This research diverges then from some of the earlier histories of medical mission by highlighting the commonalities of government and mission interests, showing how both used medicine as a means for effecting social transformation through the

⁵⁵ For example: C. Good, *The Steamer Parish: The Rise and All of Missionary Medicine on an African Frontier*, (Chicago, 2004), 43; P. Landau, ‘Explaining Surgical Evangelism in Colonial Southern Africa: Teeth, Pain and Faith’, *Journal of African History*, 37.2 (1996), 277; M. Jennings, “‘A Matter of Vital Importance’: The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39’ in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), 244; T. Ranger, ‘Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945’, *Social Science and Medicine*, 15B (1981), 261; Vaughan, *Curing Their Ills*, 55-75.

⁵⁶ J. Comaroff and J. Comaroff, *Of Revelation and Revolution* (Chicago, 1991).

⁵⁷ D. Peterson, ‘Conversion and the Alignments of Colonial Culture’, *Social Sciences and Mission*, 24 (2011), 212; E. Elbourne, ‘Word Made Flesh: Christianity, Modernity, and Cultural Colonialism in the Work of Jean and John Comaroff’, *American Historical Review*, 108.2 (April 2003), 435-59.

⁵⁸ R. Langley, ‘News of the Lepers’, *Ruanda Notes*, 41 (July 1932), 16-17.

control of a small number of individuals, just as it highlights the agency of Ugandan leprosy patients in shaping a future for themselves through life in the leprosy settlements, and the negotiations that the missionaries undertook in order to create a mutually satisfying environment.

A particularly relevant example of the blurring of the line between missionary and government medicine lies in a comparison between the colonial treatment of sleeping sickness and leprosy. Many colonial responses to these diseases were outwardly similar, not least in that Europeans endeavoured to control them by manipulating space and creating new settlements. In the Belgian Congo, the colonial government regulated and dictated where and how people were permitted to travel, and in the early twentieth century all infectious trypanosomiasis patients were supposed to be isolated in lazarets and biomedically treated, with or without their consent.⁵⁹ This would appear a typical example of intrusive government medicine, but even in these harsh measures missionaries were complicit, because they staffed the government-ordered lazarets.

Running counter to stereotype, in their handling of leprosy in Uganda the colonial government was in some ways more benevolent and lenient than the missions. Legally, the restricted movement and compulsory segregation of leprosy sufferers was possible, but practically colonial medical officials forbade the compulsory handling or segregation of any suspected or diagnosed leprosy sufferer, much to the displeasure of a number of missionaries. Similar to sleeping sickness control, leprosy control was pursued through the creation of leprosy camps (also referred to as hospitals, colonies, and settlements). It was missionaries, however, who acted as the medical aggressors, and the colonial government that felt a need to monitor them. This was not a difference intrinsic to government and mission handling of sleeping sickness and leprosy: in South Africa the segregation of leprosy patients was

⁵⁹ Lyons, *The Colonial Disease*, 110.

compulsory, and in British Tanganyika and Uganda the colonial government endeavoured to promote voluntary sleeping sickness resettlement.⁶⁰ Rather, the difference lies in the mission and government investment in each disease. Government officials viewed leprosy settlements and sleeping sickness settlements as an opportunity for the creation of model communities. Missionaries, however, were far more attracted by the idea of leprosy treatment, and whereas voluntary sleeping sickness resettlement schemes fell through because of lack of government funding and mission commitment, leprosy settlements thrived on relatively large amounts of resources spent by both the missions and government.⁶¹

Leprosy thus furnishes the opportunity for a wide range of unusual case studies, primarily through its Christian significance, its visible symptoms, and its treatment through in-patient settlements. This is reflected in histories of leprosy in Africa, completed in Nigeria, South Africa, and Mali, as well as in more globally focused scholarship on leprosy in modern history.⁶² Two African case studies have pointed to leprosy as a health concern that prompted particularly extensive collaboration between colonial government officials and

⁶⁰ S. Horwitz, 'Leprosy in South Africa: A Case Study of Westfort Leper Institution, 1898-1948', *African Studies*, 65.2 (2006), 271-95; K. Hoppe, *Lords of the Fly: Sleeping Sickness Control in British East Africa* (London, 2003), 105.

⁶¹ Hoppe, *Lords of the Fly*, 105-42.

⁶² A. Bashford and M. Nugent, 'Leprosy and the Management of Race, Sexuality and Nation in Tropical Australia', in A. Bashford and C. Hooker (eds.), *Contagion: Historical and Cultural Studies* (London, 2001), 106-28; Edmond, *Leprosy and Empire* (New York, 2006); J.D. George, "'Essentially Christian, Eminently Philanthropic'" The Mission to Lepers in British India', *História, Ciências, Saúde—Manguinhos*, 10 (2003); S. Kakar, 'Leprosy in British India, 1860-1940: Colonial Politics and Missionary Medicine', *Medical History*, 40.2 (1996), 215-30; A. Leung, *Leprosy in China: A History* (New York, 2009); J. Levison, 'Beyond Quarantine: A History of Leprosy in Puerto Rico, 1898-1930s', *História, Ciências, Saúde—Manguinhos*, 10 (2003), 225-45; Y.N. Monteiro, 'Prophylaxis and Exclusion: Compulsory Isolation of Hansen's Disease Patients in São Paulo', *História, Ciências, Saúde—Manguinhos*, 10 (2003), 95-121; L. Monnais, "'Could Confinement be Humanised?'" A Modern History of Leprosy in Vietnam', in M. Lewis and K. McPherson (eds.), *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (London, 2008), 122-38; M. Moran, *Colonizing Leprosy: Imperialism and the Politics of Public Health in the United States* (Chapel Hill, 2007); L. Navon, 'Beggars, Metaphors, and Stigma: A Missing Link in the Social History of Leprosy', *Social History of Medicine*, 11.1 (1998), 89-105; D. Obregón, 'Building National Medicine: Leprosy and Power in Colombia, 1870-1910', *Social History of Medicine*, 15.1 (2002), 89-108; D. Obregón, 'The Anti-leprosy Campaign in Colombia: The Rhetoric of Hygiene and Science, 1920-1940', *História, Ciências, Saúde—Manguinhos*, 10 (2003), 179-207; J. Robertson, 'In a State of Corruption: Loathsome Disease and the Body Politic' (University of Queensland, Ph.D. thesis, 1999); M. Worboys, 'The Colonial World as Mission and Mandate: Leprosy and Empire, 1900-1940', *Osiris*, 15 (2000), 207-218.

missionaries, and this thesis expands upon this theme in the Ugandan context.⁶³ Leprosy also provides an excellent opportunity to analyse the attempted formation of model communities: a theme that has most frequently been addressed in the history of resettlements campaigns.⁶⁴

What historians of leprosy have very rarely considered in any depth is the agency of leprosy patients in pursuing their own economic, social, and medical agendas through entry into a leprosy settlement. Notable exceptions to this in the African literature are Eric Silla and Shobana Shankar's work on leprosy in West Africa, which draw upon patient interviews to create patient narratives of the experience of institutionalisation.⁶⁵ Jane Buckingham addresses the perspective of leprosy patients in Indian leprosy settlements, exploring the extent to which leprosy patients were able to evade confinement, and take temporary advantage of the medical opportunities offered in British leprosy hospitals, even though confinement was legally compulsory.⁶⁶ Loh Kah Seng, discussing leprosy in Singapore, further describes leprosy patients not as passive victims of compulsory segregation, but rather as agents who resisted 'incarceration' and the behavioural changes expected of them, if covertly.⁶⁷ Kerri Inglis discusses the leprosy settlement at Molokai, in Hawaii, almost entirely from the perspective of its native Hawaiian leprosy patients.⁶⁸ The study of leprosy's

⁶³ J. Manton, 'The Roman Catholic Mission and Leprosy Control in Colonial Ogoja Province, Nigeria, 1936-60', (D.Phil., University of Oxford, 2004), 114-9; S. Shankar, 'Medical Missionaries and Modernizing Emirs in Colonial Hausaland', *Journal of African History*, 48 (2007), 45-68.

⁶⁴ R.S. Kipp, 'The Evangelical Uses of Leprosy', *Social Science and Medicine*, 39.2 (1994), 165-78; W.-J. Wang, 'Laying out a Model Village': George Gushue-Taylor and Missionary Leprosy Work in Colonial Taiwan', *East Asian Science, Technology, and Society*, 1 (2007), 119-27; C. Bonneuil, 'Development as Experiment', *Osiris*, 15 (2000), 258-81; G. Carswell, 'African Farmers in Colonial Kigezi, Uganda, 1920-1962: Opportunity, Constraint, and Sustainability' (Ph.D., University of London); Hoppe, *Lords of the Fly*, 111; J. Weiskopf, 'Resettling Buha: A Social History of Resettled Communities in Kigoma Region, Tanzania, 1933-1975' (Ph.D., University of Minnesota).

⁶⁵ E. Silla, *People are Not the Same: Leprosy and Identity in Twentieth-Century Mali* (Portsmouth, 1998), 27; S. Shankar, 'The Social Dimensions of Christian Leprosy Work among Muslims: American Missionaries and Young Patients in Colonial Northern Nigeria, 1920-40', in D. Hardiman (ed.) *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), 282.

⁶⁶ J. Buckingham, *Leprosy in Colonial South India: Medicine and Confinement* (Palgrave, 2002), 36-60.

⁶⁷ L.K. Seng, 'Our lives are bad but our luck is good': A Social History of Leprosy in Singapore', *Social History of Medicine*, 21.2 (2008), 302-5.

⁶⁸ K. Inglis, *Mai Lepera: Disease and Displacement in Nineteenth-Century Hawaii* (Honolulu, 2012).

history in Uganda, with its abundant documentation, provides a special opportunity to delve further into the patient's understanding of leprosy and its treatment by Christian missionaries.

From an early point historians of medicine in Africa have emphasised the importance of understanding the African patient's perspective on health and medicine, their experience of biomedicine, and the agency of therapy groups in choosing different routes to healing.⁶⁹

Historians and anthropologists have drawn on rumours, interviews, and written sources in order to discern African medical attitudes, and this thesis follows in that vein by drawing on documents, interviews, rumours, and ethnographies to discern Ugandan perceptions of leprosy and leprosy settlements during the colonial period.⁷⁰ Leprosy's special place in missionary ideology predisposed missionaries to keep extensive records on their patients, medical and narrative, and the lengthy residence of most leprosy patients in the settlements meant the missionaries had more opportunity to learn about and write about their patients. Combined with photographs, government records, and thousands of individual patient records remaining at two former leprosy settlements, these writings build a corpus of information about leprosy sufferers that is larger and more detailed than can be found for any other group of Ugandans. As such, it offers a new contribution to medical history and Ugandan history.

The history of Uganda is a small but growing field, which in recent decades has been focused primarily on Buganda, with the rich sources that the region and its people provide. While this thesis touches on the leprosy settlement that was founded on the edge of Buganda, the bulk of Uganda's leprosy patients were treated in settlements outside of Buganda. This project therefore adds more substantially to the portion of histories that focus on other regions of Uganda, with samples from eastern (Teso and Busoga, and western Uganda (Kigezi).

⁶⁹ Feierman, 'Struggles for Control: The Social Roots of Health and Healing in Modern Africa', *African Studies Review*, 28.2/3 (1985), 73-147; J. Janzen and W. Arkininstall, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley, 1978); G. Prins, 'But What Was the Disease? The Present State of Health and Healing in African Studies', *Past and Present*, 124 (1989), 159-79.

⁷⁰ L. White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, 2000) is notable for its pioneering use of rumours as a source.

Unfortunately, very little about Uganda's former Northern Province is included, which due to its late integration into the Ugandan Protectorate and the recent challenges of undertaking historical research in a time of conflict, is all too common an omission in histories of Uganda.⁷¹ The reason for this neglect is that no large-scale leprosy settlement was founded in northern Uganda until 1951, at Kuluva in the West Nile District, and although the CMS missionaries at Teso made medical safaris into and admitted patients from Acholi and Lango, there is not enough information about leprosy in this region to make it a central case study within this thesis.⁷²

The study of leprosy settlements in colonial Uganda, while narrow in the primary source material with which it engages, draws on and contributes to a variety of historical fields, including African medical history and the agency of African patients within colonial biomedical systems; mission and medical mission history; Ugandan history; and the history of colonial childhood, which is discussed in more detail in Chapter 4.

Methodology

This thesis draws on published mission and medical journals, archival sources in England, Ireland, Uganda, and Kenya, and oral interviews with former Ugandan leprosy patients in order to reconstruct a picture of mission, government, and patient priorities and perspectives on leprosy settlements in colonial Uganda. My fieldwork in Uganda was undertaken in three separate research trips, totalling about eight months, between June 2009 and August 2011. I also unsuccessfully searched for relevant archival material in Rwanda.

⁷¹ There are a number of exceptions, including: R. Atkinson, *The Roots of Ethnicity: The Origins of the Acholi of Uganda Before 1800* (Philadelphia, 1994); G. Carswell, *Cultivating Success in Uganda: Kigezi Farmers and Colonial Policies* (Oxford, 2007); D.W. Cohen, *The Historical Tradition of Busoga, Mukama and Kintu* (Oxford, 1972); S. Doyle, *Crisis and Decline in Bunyoro* (Oxford, 2006); D. Peterson, 'States of Mind: Political Vision in the Rwenzururu Kingdom, Western Uganda', in D. Peterson and G. Macola (eds.), *Recasting the Past: History Writing and Political Work in Modern Africa* (2009), 171-190; J. Vincent, *Teso in Transformation: The Political Economy of Peasant and Class in Eastern Africa* (Berkeley, 1982).

⁷² RCA, Minutes of Uganda's BELRA Committee Meeting, 19 April 1951.

Although most of the day-to-day maintenance in Uganda's leprosy settlements fell to the Church Missionary Society and the Franciscan Missionary Sisters for Africa, there were a number of other missions, charities, and governments that were also involved in the settlements' administration, and these archives have been instrumental in researching this thesis. By cross-referencing these mission, government, charity, hospital, and interview sources, which I organised chronologically by settlement, I have endeavoured to construct a picture of life in Uganda's leprosy settlements from as rounded a perspective as possible.

The greatest methodological challenge faced in writing this thesis is the imbalance of sources available from the CMS versus Catholic leprosy settlements. Uganda's CMS missionaries, and in particular the Ruanda Mission missionaries who ran the leprosy settlement at Lake Bunyonyi, wrote prolifically and occasionally even candidly about their leprosy work. The CMS archives at the University of Birmingham have been well preserved and catalogued, and include mission publications, administrative records, and personal missionary collections.

The records of Uganda's Catholic leprosy missionaries, on the other hand, are much less extensive. The MHM headquarters archive in Freshfield, England, has a wealth of archival material about Uganda, but it comes primarily from the collection of the MHM bishops in Uganda, who had relatively little to do with the leprosy settlements. Nyenga and Buluba had only one part-time MHM chaplain each, and the archive holds personal material for only one of these priests. The FMSA mother convent in Dundalk, Ireland, holds more extensive records of the settlements at Nyenga and Buluba, in accordance with the predominance of the FMSA Sisters in running the leprosy settlements. However, most of these records are administrative in nature, such as annual hospital reports and correspondence with British charities. This has created a particularly notable imbalance in the availability of personal accounts of leprosy work, which is to say, unpublished letters to mission

headquarters or among friends that more candidly discuss the life and problems of each leprosy settlement.

One means of addressing this imbalance in available CMS versus Catholic leprosy settlement sources was through colonial government archives in Uganda. District government officers were heavily involved in the administration of each leprosy settlement. Remaining district archives provide a window not only into the role of the government in leprosy mission, but also into some of the challenges that missionaries, leprosy patients, and their families faced, for which they occasionally appealed to government officers for help.

I searched for district archives in Soroti, Kabale, Kampala, and Jinja, which were the headquarters for the respective district governments of Kumi, Lake Bunyonyi, Nyenga, and Buluba. In Soroti, Kabale, and Jinja, the current district Records Officers act as custodians for remaining district and provincial archives. These archives are in varying states of preservation: floods, termites, and other elements of nature have damaged records, and record disposal due to shortage of space, misunderstandings, or political and military conflict has depleted each archive. Soroti is the only one of the three archives in possession of a complete listing of available files, and no district files relating to medicine are available at all in Buganda (for Nyenga). Each of these district archives contains a small wealth of sources pertaining to leprosy in the colonial period, but unfortunately the loss of archival material over the years and the physical difficulties of working in these endangered archives has meant that the material gathered from them is incomplete, often covering a span of five years or so in detail, and neglecting the remainder of the period under study. Although they are currently in disarray, the district archives at Kabale and Jinja have been catalogued several times in the past. As each file has several different number series that label it, when footnoting material from these archives I have used the descriptive title written on the file as a reference, instead of a number.

The National Archives in Entebbe and the Medical Department archives in Kampala have suffered similar deprivations, and while the National Archives is currently being catalogued and preserved, at the time of research, the majority of files on leprosy indexed during the colonial period were unavailable. The Directorate of Health offices in Jinja also hold a limited collection of records, some pertaining to leprosy in eastern Uganda in the postcolonial period.

Of Uganda's four original leprosy settlements, three remain hospitals while the fourth is a school. All remain under the administration of the churches to which the missionaries bequeathed them. Kumi Hospital is maintained by the Anglican Church of Uganda, and Nyenga and Buluba are administrated by the Ugandan Little Sisters of St. Francis, under the auspices of the Catholic Church. Mission records remain in the custody of both churches, and a small amount of information on leprosy settlements was available at a CMS archive at the Uganda Christian University in Mukono, and at an MHM archive in the Bishop's House in Jinja.

Far more archival information remained at the three hospitals that originated as leprosy settlements. Kumi and Buluba have preserved thousands of leprosy patient records dating back to the 1930s. These records are incomplete and focus primarily on patients who entered the settlements from the late 1940s and onwards, when patient turnover increased drastically with the use of sulphone drugs. At Kumi, only the adult leprosy patient records have survived. However, analysed together these patient records are a valuable source of information about each settlement's patients. They tell us who these patients were: their names, ethnicity, place of origin, age, gender, religion, physical and medical condition, and more. For patients who stayed in the settlements for many years, added pages indicate not only their medical history, but sometimes even their religious conversion, how long they stayed in the settlement, whether they left with or without permission, whether they were

expelled for bad behaviour, and even how many visits they made home. In order to preserve the privacy of these former leprosy patients, I do not use names or personal details from any individual patient record, but instead analyse overall trends within the records. Kumi, Buluba, and Nyenga also contain small remnants of administrative records and patient registers from before 1951, and greater quantities from the 1950s onward.

Interviews are a particularly important source of information for this thesis, especially in elucidating the perspective of the leprosy patients who lived in Uganda's leprosy settlements. With the assistance of three translators, I conducted interviews with former leprosy patients in Lusoga, Luganda, Iteso, and Rukiga. I interviewed 42 former patients in total, 16 at Buluba, 12 at Nyenga, 11 at Kumi, and three in Kigezi. Only eight of these men and women entered the settlements in 1951 or earlier, but while the remaining 34 did not live in the settlements during the period under study, their interviews still shed light on the experience of living with leprosy. At Buluba and Nyenga, I interviewed all leprosy patients resident in the hospital grounds who had been treated for leprosy before 1980, and additionally conducted a handful of interviews with former leprosy patients who lived on plots adjacent to the hospital and visited regularly. At Kumi, I also interviewed all of the resident leprosy patients, but with the assistance of my local translator, sought out available former patients who still lived within a few miles of the hospital. As Kigezi's leprosy settlement was disbanded in 1967, interviews could only be conducted with those former patients who were still on the register of the District Leprosy and Tuberculosis Officer, and lived within easy driving distance of Kabale.

Some historians of leprosy choose not to use formal interviews with leprosy patients in their research, due to ethical concerns of singling out a former leprosy patient for attention in areas where leprosy is stigmatised.⁷³ Most of the leprosy patients I interviewed, however,

⁷³ Manton, 'The Roman Catholic Mission and Leprosy Control', 31.

still live at the hospitals where they were initially admitted. All remaining patients interviewed were either locally acknowledged as former leprosy patients, or living in areas where leprosy is minimally stigmatised, and were willing to discuss their early memories of leprosy and life in the settlements. However, in order to preserve some privacy, I record only the first names of patients.

In asking former leprosy patients to remember experiences of six or seven decades past, memories are subject to change and bias. For example, the hospitals have provided lifelong support for some of these men and women, and under these circumstances many were reluctant to express negative opinions about the hospitals and their former missionaries. The interviewees were far more open in their recounts of their personal experiences of contracting and living with leprosy, their relationships with fellow leprosy sufferers, and their interactions with family and local communities. Although coloured by the passage of time, and also affected by the intermediary role of translators, these interviews have still provided a valuable source of information about the history of leprosy in Uganda, particularly when collated with written mission and government accounts and colonial and contemporary ethnographic materials. In addition to speaking with former leprosy patients, I also conducted interviews with former Ugandan leprosy staff, though primarily from the postcolonial time period, and with FMSA and CMS missionaries who worked in Uganda's leprosy settlements, or who grew up nearby as the children of CMS doctors.

Finally, I have supplemented mission and government archival material and interviews in the United Kingdom, Ireland, and Uganda, with archival materials from a number of British charities that provided financial and staff support to Uganda's leprosy settlements. These include the Mission to Lepers, which supported the CMS leprosy settlements, the St. Francis Leper Guild, which supported the FMSA leprosy settlements, and Toc H and BELRA, which supported all of Uganda's leprosy settlements.

Missionaries, colonial and local government officials, charities, and leprosy patients all contributed in shaping life within Uganda's leprosy settlements, and this thesis accordingly draws on written and oral sources from all of these actors to reconstruct a story of leprosy settlements in Uganda between 1927 and 1951.

Thesis Summary

The first of the six chapters that structure my thesis contrasts the medical mission ideologies of the CMS with those of the FMSA and MHM with a view towards understanding their differing approaches to leprosy settlement in Uganda in the context of competition for Christian converts. Although medical mission has long been an area of interest for historians, no scholarly works have ever compared the ideologies and resources that differentially affected Catholics and Protestants in their medical mission to Africa. In this thesis, I address this gap by using mission-run leprosy settlements as a lens through which to examine the effects that the differing religious and social ideologies of these missionaries had on the character of medical mission, and on the experiences of the Ugandans who lived in leprosy settlements. Uganda provides a particularly significant backdrop for such an exploration, as the relatively small number of mission societies present before the 1940s contributed to an intense competition between Protestant and Catholic missions and their converts, the aftermath of which is still felt in Uganda today.

The second chapter builds on this discussion of the European influences that shaped leprosy settlements in Uganda by exploring the involvement of Uganda's colonial government in the treatment of leprosy. It assesses relationships between missionaries and government officials, based on their national and religious affiliation, at a local and central level; explores the similar ideologies and goals of these individuals; and discusses the ways that these similarities shaped the provision of a system of leprosy treatment in Uganda that was collaborative and yet extremely limited in its scope and effectiveness by the standards of

public health. In its exploration of the cooperation between missionaries and colonial government officials over the treatment of leprosy in Uganda, this thesis offers a new perspective on relations between the secular and religious in the colonial era. Early historiography on medicine in British colonial Africa suggests that colonial government and missionary medicine occupied two relatively distinct spheres, and that government officials viewed medical missionaries with suspicion and distrust. Contrary to this paradigm, this thesis suggests that missionaries and colonial government officials collaborated extensively and amicably in the treatment of leprosy in Uganda. The mutual social and cultural priorities of missionaries and government administrators led to a system of isolated, in-patient leprosy care that was limited in scope and reflective not of a goal for the public health of Uganda, but rather a vision for the future of Uganda as a ‘civilised’ and Christian country.

The third chapter explores the enactment of the mission goal for a ‘civilised’ and Christian Uganda through their attempts to create ‘model villages’ and model lives within leprosy settlements. The greatest hope of Uganda’s leprosy missionaries was that the leprosy sufferers under their care would transcend their ‘primitive’ Ugandan backgrounds to lead model lives under the healthy, civilised, and Christian influence of the settlements’ European and Ugandan staff. This chapter explores the missionaries’ attempts to enact that goal through an analysis of each settlement’s design, from its site, layout, and construction to the social, political, and economic organisation and facilities that the missionaries provided.

The fourth chapter provides an even closer analysis of mission attempts to socially engineer lives within Ugandan communities by focusing on children within leprosy settlements, who far more successfully embodied the model of modernised and Christian leprosy patients than their adult counterparts. This role was so successfully played because in their youth and their separation from families, children were more easily influenced by missionaries’ endeavours to ‘civilise’ and evangelise. There is very little historical literature

on children in Africa; most of it is focused either on child labour, or on the institutions in which children were educated. This chapter examines the special role that children had in the eyes of missionaries as vulnerable and impressionable individuals, and the ways that life within a leprosy settlement changed the social experiences of these children.

The final two chapters of the thesis bring out the perspective of the patients who lived in Uganda's leprosy settlements. The fifth chapter begins by introducing the residents of Uganda's leprosy settlements, offering such background information as their age, gender, ethnicity, religion, and medical condition. It then goes on to discuss the reasons that leprosy patients entered the settlements, highlighting the range of actors who were involved in these decisions. It concludes with an exploration of how these actors, including relatives, local authorities, and chiefs, remained involved in the lives of leprosy in-patients and the functioning of the leprosy settlements.

The sixth chapter of the thesis assesses interactions between Ugandan leprosy patients, European missionaries, and other settlement staff, exploring the negotiations upon which the leprosy settlements were built. It discusses patients' physical and emotional experiences of leprosy in the settlements, offering a counter-narrative to the missionary and government ideals of 'civilisation', Christianity, and biomedicine that are described in the first four chapters of the thesis. It then explores some of the day to day compromises and arguments between patients and missionaries over their lifestyle and priorities. The leprosy settlements had a small staff and even smaller missionary presence, and as such, Uganda's leprosy patients had great power to negotiate the shaping of their own lives, even within the confines of the settlements. The chapter then concludes with a discussion of how and why patients came to leave the leprosy settlements.

Although leprosy has been an area of great interest for historians of medicine, the question of the social environment within leprosy settlements, and the differential influence

that Catholic *and* Protestant missionaries exerted upon this environment, has not been thoroughly examined for Africa. Drawing on a wealth of new sources that go beyond National and mission archives to informal collections that are very rarely accessed, this thesis aims to fill a gap in the study of leprosy institutions by focusing on the religious and social experiences of Ugandan leprosy patients, and the ways that the involvement of Catholic and Protestant missionaries and government officials impacted upon these experiences. In so doing, the thesis explores three main topics: the ways in which the differing goals, ideologies, and resources of the CMS and FMSA shaped the formation of and social environment within Uganda's leprosy settlements; the ways in which the priorities of and relationships between leprosy missionaries and government officials shaped the lives of patients within the settlements; and how missionaries and Ugandan leprosy patients interacted over the missions' social, religious, and medical agendas.

Chapter 1: ‘They will take everything from us’: The Ideology and Practice of Catholic and Protestant Leprosy Mission in Uganda

In the four years between 1930 and 1934, Protestant and Catholic missionaries founded Uganda’s first and only large-scale leprosy settlements. The rapid foundation and growth of the four leprosy settlements at Kumi (and Ongino), Lake Bunyonyi, Nyenga, and Buluba, was an expression of these missions’ growing belief in the importance of medicine in Christian service; their conviction that leprosy sufferers would make especially sincere Christian converts; and their perception of the inter-denominational competition for Ugandan converts.¹

The first section of this chapter provides a background for the development of leprosy mission in Uganda through an examination of the development of Ugandan medical mission. The second section compares the differential ideologies of Catholic and Protestant medical mission, which influenced the provision of biomedicine in Uganda. Leprosy, with its long Christian history and symbolic importance, played a particularly important role in African medical mission, and the third section continues by exploring the ideology of leprosy mission through the writings of the CMS and FMSA missionaries who undertook leprosy work in Uganda.² Finally, these discussions of medical mission ideology and the development of Ugandan mission culminate in a comparative analysis of Catholic and Protestant leprosy settlements.

While numerous historians have written about medical mission in Africa, none have compared the ideology and practice of Catholic versus Protestant medical mission, possibly because the scope of such an exercise would be too great for analysis. A study of leprosy in Uganda, however, provides an ideal limit within which to pursue a comparison. In any given African colony, medical mission and leprosy mission was usually undertaken by a variety of

¹ Kumi and Ongino were two halves of one large CMS leprosy settlement, and henceforth both will be referred to as ‘Kumi’, which is how the missionaries and colonial government colloquially referred to both settlements.

² M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, 1991), 75.

societies from around the globe. In Uganda, however, only two missionary societies were heavily involved in leprosy mission, and the similar national origins of these missions allows a deeper comparison of the medical mission policy that they undertook. Each mission society approached medical work differently, if at all, and not all of the findings from a comparison of leprosy mission in Uganda can be broadened to apply to Catholic and Protestant mission in general. However, many of the ideological motivations and practical realities that shaped the CMS and FMSA's leprosy work were shared by missionaries across Africa.

Limited in their financial and staff resources, and driven by a religious conviction in the Bible's importance as the source of conversion and salvation, the CMS missionaries established large leprosy settlements organised along a hierarchical structure that promoted self-sufficiency and family life, emphasised the acquisition of literacy and technical skills, and relied heavily on the authority and expertise of Ugandan staff. The FMSA missionaries, on the other hand, with their belief in good works as the source of salvation and behaviour as the measure of conversion, founded smaller leprosy settlements where greater numbers of European missionaries and a more centralised settlement layout meant closer oversight of individual leprosy patients, in the name of moulding Christians and thus saving their souls.

The Development of Medical Mission in Uganda

Missionaries provided the earliest and most extensive biomedical care in colonial Uganda, the CMS foremost among them. For most of the nineteenth century, biomedicine in Uganda was supplied by Europeans with little formal biomedical training. The explorers and missionaries who travelled to Uganda carried with them some biomedical knowledge and a kit of biomedical supplies, for the maintenance of their own health, if nothing else. From as early as 1862, when the British explorer John Hanning Speke arrived in Uganda, biomedical treatment was offered to the Kabaka and his court. After the brief sojourn of CMS medical missionary Dr. Felkin in 1879, biomedicine became a more regular aspect of missionaries'

interactions with Bagandan elites, and the treatment that Felkin offered for the Kabaka's illness warmed the Kabaka's attitude towards the mission. Even after Felkin left Uganda, both CMS and Catholic missionaries continued practicing medicine, some going so far as to undertake minor surgeries. Biomedicine became part of the competition between Protestant and Catholic missionaries, and although the CMS occasionally sent a biomedical doctor to Uganda for a short time, for twenty years CMS and Catholic medical mission were on roughly equal footing, as neither had ready access to the biomedically trained doctors or nurses who could increase the standard of medical treatment provided to Bagandans.³

It was not until 1897 that the nature of biomedical practice in Uganda began to change, when CMS Dr. Albert Cook opened Uganda's first hospital at Mengo, with the assistance of his future wife, CMS nurse Katherine Timpson. From this point onward, the CMS went about expanding their medical mission to Uganda. Two more doctors and two more nurses arrived between 1899 and 1904, allowing Mengo to grow in its size and capabilities, and allowing for the foundation of another CMS hospital in 1903 in Toro, which moved the CMS medical mission outside of Buganda. Overburdened by the responsibilities of providing ever more popular biomedical treatment to hundreds of patients a day, as well as evangelising, the missionaries also trained Ugandan men and women as assistants. This eventually led to the foundation of Uganda's first formal, diploma-granting medical school, which the CMS opened at Mengo in 1917 for the training of clinical assistants who could oversee rural dispensaries and assist in CMS and government hospitals. Shortly thereafter, Mrs. Cook founded Uganda's first school for midwives, the Lady Coryndon Maternity Training School, which offered women the opportunity to achieve government certification as midwives, after which they would be placed in one of the many rural CMS maternity and child welfare centres. This scheme was so successful that the Governor's wife in

³ D. Zeller, 'The Establishment of Western Medicine in Uganda', (Ph.D., Columbia University, 1971), 60-99.

neighbouring Kenya requested Ugandan midwives to begin her own maternity scheme, and in 1927 Uganda became the first British colony in Africa to pass an ordinance regulating the training and practice of midwives. This was followed by the foundation of the Mengo Hospital Nurses Training School in 1931. Meanwhile, the CMS continued to expand their medical work throughout the Ugandan Protectorate, opening dispensaries, maternity centres, and two more hospitals, in Kigezi and Teso.⁴ From these two hospitals were founded both of the CMS leprosy settlements, first at Kumi in Teso (1930), and then at Lake Bunyonyi in Kigezi (1931).

While the CMS expanded their provision of biomedical care and training, transferring medical treatment from the hands of informally experienced missionaries to biomedically trained doctors, nurses, and Ugandan staffers, the Catholics also transitioned from informal medicine to formal medical institutions, but more slowly. The Catholic missions, now including the White Fathers and the Mill Hill Mission (MHM) from England, had no wish to be outdone by the CMS in the provision of medical care, for they recognised biomedicine as a potentially effective evangelising tool and an important aspect of compassionate mission. They therefore attached dispensaries to their mission stations, where biomedical treatment was offered to Ugandan men on a limited basis. For a time, all White Fathers were required to undertake medical training during their novitiate, which enabled them to effectively provide basic medical treatment. However, it was primarily Catholic nuns who were responsible for the provision of Catholic biomedical treatment in Uganda. In 1899, the first White Sisters arrived in Uganda, and they opened a hospital for the care of sleeping sickness patients at Rubaga in Kampala, two years after the foundation of the first CMS hospital.⁵ Unlike the CMS hospital, however, the hospital staff had no formal training in biomedicine. Although the White Sisters expanded their medical treatment throughout Uganda, opening

⁴ Zeller, 'The Establishment of Western Medicine in Uganda', 100-31.

⁵ C. Ferlay, 'Les Pères Blancs et les "Anglais" au Buganda de 1879 à 1929' (Ph.D., Université Paris I Pantheon Sorbonne, 2007), 282.



Figure 1: Mother Kevin, FMSA, Photograph Album 'Snaps from Various Missions'

dispensaries and hospitals, it was years before they obtained the services of a biomedically trained doctor or nurse.

The Franciscan Sisters of St. Mary's Abbey in Britain, invited to Uganda by the MHM in 1903, were the other main providers of Catholic biomedicine in Uganda. The nature of their biomedical staffing was quite similar to the White Sisters: none of the Sisters had formal biomedical training, but three of the first six had experience in home nursing, and they relied much on the advice of the CMS doctors at Mengo.⁶ Led by the indefatigable Mother Kevin from 1910 (see Figure 1), and with the support of the MHM Bishop Biermans, they were to prove the main innovators in Catholic healthcare in Uganda. In 1906, the Franciscan sisters opened their first hospital at Nsambya. While the hospital work grew successfully, Mother Kevin felt strongly that the needs of mothers and infants were not being met, and moreover she was keenly aware of the CMS endeavours to fill this gap in Uganda's medical care. As a Franciscan Sister wrote in her biography of Mother Kevin in 1964:

⁶ Sr. Louis, *An Unfinished Canticle: The Story of the Franciscan Missionary Sisters for Africa* (1980), 18.

The team of doctors and nurses at Mengo Hospital had established a Maternity Centre which was bringing untold blessings to the country. The Catholic Missions had nothing. The matter was reaching a crucial point, as the Government was prepared to finance the establishment of a Midwifery Training School for African girls, and the management of this would, naturally, fall to the Agency which had the staff and facilities.⁷

The CMS was that agency, and they founded the Lady Coryndon Midwifery Training School in 1918. But Mother Kevin was not about to be outdone, or to lose her most promising students to Protestant schools, and on a visit to Ireland in 1920 she was able to recruit a young lady doctor, Evelyn Connolly, who agreed to start a maternity training school at Nsambya in 1921.⁸ Having already given their support to the CMS midwifery school, the colonial government initially refused financial support to Mother Kevin's Catholic midwifery school, but Mother Kevin nonetheless secured their authorisation for its opening.⁹ In 1930, she expanded the midwifery school into a Nursing Training School, for once ahead of the CMS, who founded their nursing school in 1931, though Mother Kevin still had only one doctor to look after the school and the hospital, and therefore could not train nearly as many students as the CMS.¹⁰ In 1932 and 1934, again following a few years in the footsteps of the CMS, Mother Kevin pioneered Catholic leprosy mission in Uganda as well, founding leprosy settlements at Nyenga and Buluba respectively.

While CMS medical missionaries helped their fellow Catholic missionaries with some medical issues, and individual missionaries occasionally formed friendships with each other across denominational lines, overall medical mission was a source of great competition between the Catholics and Protestants. The Catholics envied the CMS their well-equipped hospitals and their ability to offer more diverse and advanced medical services, while the CMS frowned upon Ugandans attending Catholic dispensaries and hospitals, fearful of the

⁷ Sr. M. Louis, O.S.F., *Love is the Answer: The Story of Mother Kevin* (Dublin, 1964), 97.

⁸ Sr. Louis, *Love is the Answer* 102.

⁹ Sr. Louis, *Love is the Answer* 115.

¹⁰ Zeller, 'The Establishment of Western Medicine in Uganda', 145.

damage that untrained medical personnel could do by incorrectly treating patients.¹¹ In spite of their best efforts the Catholic missionaries in Uganda were never able to catch up to the CMS in their medical provision. This was not necessarily because the Catholic missionaries in Uganda placed less value on medical mission, or because they had fewer financial resources, but rather because canon law prohibited members of Catholic religious orders from practicing medicine.

Until the twelfth century, Roman Catholic religious had a sterling reputation for tending the sick, but from the twelfth to twentieth centuries the Catholic Church issued a series of prohibitions to limit the involvement of religious in medical work. In the twentieth century, the *Norms for the Approbation of New Institutes*, passed in 1901 and repeated in 1921, prohibited members of Catholic religious orders from aiding or attending women in childbirth or in maternity homes. In 1917, the *Code of Canon Law* prohibited religious from practicing medicine or surgery. While these prohibitions were not absolute, exceptions being allowed on special dispensation from the Pope, in practice very few exceptions were made for male religious, and none for female religious.¹² These prohibitions on medical work, for women especially, arose out of a concern that chastity would be endangered by the intimate human contact integral to medical practice.¹³ In some countries, such as the United States, religious were more likely to controvert these strictures, but Irish religious steadfastly adhered.¹⁴ Needless to say, such prohibitions were not conducive to Catholic mission work, and Uganda's Catholic missionaries struggled to keep up with the Protestants' provision of medicine. Unable to pursue formal biomedical training, the missionaries were left to learn through personal experience tending the ill, unless they could recruit a lay doctor. The

¹¹ Zeller, 'The Establishment of Western Medicine in Uganda', 148-9.

¹² E. Hogan, *The Irish Missionary Movement* (Dublin, 1990), 106-7.

¹³ C. Clear, *Nuns in Nineteenth-Century Ireland* (Dublin, 1987), 75.

¹⁴ Carmen Mangion, 'Spiritual and Professional: Catholic Women Religious and Foreign Medical Missions, 1900-1936' (paper, Christian Missions in Global History Seminar, Institute for Historical Research, 10 November 2009).

recruitment of lay doctors was a particular challenge; unlike Protestant missions, which were accustomed to sending out male missionaries and their families, Catholic missions were centred upon individuals who were part of a religious order. Most of the single Catholics inclined to mission work wanted to join a religious order. Dr. Evelyn Connolly, the first biomedical doctor to work for the Catholic mission in Uganda, spent ten years in Uganda before following in her sister's footsteps and joining the Franciscan Sisters of St. Mary's Abbey, most likely waiting this long only because the mission did not have another doctor available. When she returned to Uganda in 1933, she was no longer allowed to make use of her medical training in the same way as she had before.¹⁵

In 1936, after decades of campaigning by missionaries and others who shared their interests, the Catholic Church issued the Instruction *Constans ac Sedula*, which not only permitted religious to practice midwifery, but encouraged it. The Instruction also allowed for an increased number of special dispensations for members of the religious to practice medicine and surgery.¹⁶ Mother Kevin was one of the foremost campaigners for the lifting of midwifery prohibitions, with the support of Uganda's Bishop Biermans. Though Mother Kevin was refused a special dispensation to obtain midwifery certification in 1919, she continued campaigning whenever she was on leave in Europe.¹⁷ Yet in spite of the campaigners' success in lifting the prohibitions against religious practicing maternal and infant healthcare, Catholic medical mission was never able to reach the scope of Protestant medical mission in colonial Africa. After decades of mission, education had become firmly entrenched as a priority of Catholic mission, and given the growing demand for education in the African colonies, it was difficult to divert staff and resources for less established medical missions. Mother Kevin placed great value on medical mission, but even among the order that she founded, the Franciscan Missionary Sisters for Africa, building a corps of

¹⁵ Sr. Louis, *An Unfinished Canticle*, 53.

¹⁶ Hogan, *The Irish Missionary Movement*, 107-8.

¹⁷ Hogan, *The Irish Missionary Movement*, 114-5.

missionaries with formal biomedical training was a slow process. In 1936, the FMSA had one medically trained sister, and by 1973 they had 74, who accounted for nearly a third of their missionary members.¹⁸

Over the course of the colonial period, the missions became increasingly dependent upon the aid of the government for the growth and diversification of their medical provisions. In the earliest years of the Protectorate, the colonial government left medical work entirely in the hands of the missions, intervening only in cases of medical emergency, namely in response to epidemics of sleeping sickness and venereal disease.¹⁹ After World War I, however, the government began to take a greater interest in healthcare, both because its benevolent provision became a means of justifying colonialism, and because increased economic growth necessitated a healthy labour force.²⁰ Consequently the government began opening their own hospitals and dispensaries, and providing financial assistance for the medical missions, who continued to dominate in two fields of healthcare: maternity and child welfare, and leprosy work.

Catholic and Protestant Ideologies of Medical Mission

Although medicine was an informal part of mission from its earliest days, it was not until the second half of the nineteenth century that missionary societies began developing dedicated medical missions.²¹ Many missionaries worried that practicing medicine would interfere with more traditional evangelical activities such as preaching. When the CMS Medical Mission Auxiliary sent Dr. Cook to Uganda to open a medical mission, the missionaries already present in Uganda objected to and obstructed Cook's medical work for a year, feeling that medical mission was too costly and Dr. Cook could more effectively

¹⁸ Hogan, *The Irish Missionary Movement*, 121.

¹⁹ Zeller, 'The Establishment of Western Medicine in Uganda', 207.

²⁰ Zeller, 'The Establishment of Western Medicine in Uganda', 208.

²¹ P. Williams, 'Healing and Evangelism', in W.J. Shiels (ed.), *The Church and Healing* (Oxford, 1982), 271.

evangelise in other ways.²² Over time, however, a growing number of missions came to believe in the humanitarian necessity and evangelistic value of medicine, especially as a means of attracting an audience when all other methods failed.²³ In the twentieth century, medical mission came increasingly to focus upon the care and treatment of mothers, infants, and leprosy sufferers as a fulfilment of their evangelistic and humanitarian goals.

The CMS was one of the largest Protestant mission providers of biomedicine globally, and as such their medical ideologies are a good representation of the predominant Protestant medical mission ideology in general. In 1943, by one author's reckoning, the CMS was responsible for more than half of the medicine provided by Anglican societies, and a tenth of all Protestant medical service overseas.²⁴ Their medical mission, and Protestant medical mission more generally, was based upon the theological conviction that the Gospel called for the redemption of the body as well as the soul. However, in the nineteenth century, this belief was not widespread, which was accounted one of the primary obstacles to the growth of medical missions.²⁵ It was not until the twentieth century that Protestant medical mission was fully fledged and considered as important as other forms of evangelism. Medicine was not just a supplement to other forms of evangelism, but also a core component of any mission that aspired to follow Christ's work. Christ relieved human suffering and healed the sick, and it was therefore the responsibility of missions to follow in his footsteps by promoting the physical as well as spiritual health of potential converts.²⁶

Catholics believed that medical mission was an observance of the commandment of charity, a following of Christ's example, and above all, an avenue for the manifestation of

²² Zeller, 'The Establishment of Western Medicine in Uganda', 101.

²³ Williams, 'Healing and Evangelism', 276; A.F. Walls, 'The Heavy Artillery of the Mission Army', in W.J. Shiels (ed.), *The Church and Healing* (Oxford, 1982), 290.

²⁴ P. Garlick, *The Wholeness of Man* (London, 1943), 130.

²⁵ Garlick, *The Wholeness of Man*, 133.

²⁶ *The World Mission of the Church: Findings and Recommendations of the Meeting of the International Missionary Council* (London, 1939), 93-4.

Christ through the ministry of Healing.²⁷ Yet even as the CMS was reformulating its medical mission policy in 1930 and other Protestant mission societies were waxing enthusiastic about medical mission, many Catholics continued to express anxieties about the value and future of medical mission.²⁸ A particularly strong concern was that potential converts would believe that missionaries were exploiting their suffering and poverty in order to evangelise.²⁹ It was not until after Pope Pius XI's 1936 Instruction *Constans ac Sedula* that Catholics were really able to champion the foundation of medical mission sisterhoods and the practice of medicine only by those who were properly trained for the task.³⁰

The Christian Ideology of Leprosy Mission

While Catholic and Protestant missionaries shared a belief in leprosy as an evangelistic tool, they differed in their understandings of the theology and value of leprosy mission, and in the way that they discussed the relationship between leprosy and Christianity in written documents. This section will explore those differences through the writings of Uganda's leprosy missionaries. For the Protestant CMS missionaries, leprosy mission was a fulfilment of Christ's example; a unique opportunity for evangelisation because it brought new populations into extended contact with the mission; and a measure of relief from the pain and suffering of leprosy's more debilitating symptoms. For the Catholic FMSA missionaries, leprosy mission was a fulfilment of the example of St. Francis and a way of becoming closer to Christ; an opportunity to secure particularly sincere converts to Christianity; and a means of securing a life after death for suffering leprosy patients.

²⁷ Sr. Louis, *Love is the Answer*, 112.

²⁸ R. Baker, 'The Presentation of the Gospel to Non-Civilised Peoples', in E.R. Morgan (ed.), *Essays Missionary and Catholic* (London, 1928), 58; E.R. Morgan, 'Missions and Governments', in E.R. Morgan (ed.), *Essays Missionary and Catholic* (London, 1928), 163-4.

²⁹ Sr. Louis, *Love is the Answer*, 112-3.

³⁰ A. Dengel, *Mission for Samaritans: A Survey of Achievements and Opportunities in the Field of Catholic Medical Missions* (Milwaukee, 1945), 3.

Many of the missionaries, both Protestant and Catholic, who dedicated themselves to leprosy mission in Uganda did so because they felt a special calling from God to follow in Christ's footsteps and 'cleanse the lepers'.³¹ Healing leprosy sufferers was 'the most Christ-like work anyone can do', and CMS missionaries wrote often that in healing leprosy they were following in the footsteps of Christ. As the CMS nurse Miss Langley wrote: 'I am so glad that [lepers] appealed to Christ as they did, because He has set us an example'.³² Moreover, Christ's example was quite visibly present in the missionaries' treatment of leprosy patients: a picture of Christ cleansing a 'leper' hung on the wall of the CMS Ongino settlement's examination room.³³

The FMSA connected leprosy to Christ not as a role model with compassion for leprosy sufferers, but rather through his status as a sufferer himself. As one Sister wrote, 'Though life's weary vale of tears the lepers may walk alone – but in the bosom of the Catholic Church they are loved and wanted because of Him Who was esteemed "as a leper."' ³⁴ 'Him' was a reference to Christ, who ended his life suffering and outcast, just as leprosy sufferers supposedly endured their lives. When the FMSA missionaries wrote of a role model for compassion and love towards the leprosy sufferer, they usually pointed to one of Christ's saintly followers as an exemplar: St. Francis of Assisi. One of St. Francis' many recorded attributes was his compassion towards the leprosy sufferer. St. Francis' hagiographers wrote of his Christ-like ability to transcend physical abhorrence of the leprosy sufferer's disfigured condition in order to kiss or embrace the 'leper'.³⁵ In overcoming his revulsion to embrace the 'leper', St. Francis was re-enacting Christ's love for the 'leper' and

³¹ Matthew, 10:8.

³² R. Langley, 'Account of Answered Prayer', *Ruanda Notes* 43 (1933), 12.

³³ E.B. Bull, 'Opening of the Ongino Leper Colony and Dispensary', *Mission Hospital*, 39.447 (April 1935), 91.

³⁴ 'Our Least Brethren the Lepers', *Day Star in Africa*, 8 (January 1948), 20.

³⁵ Thomas of Celano, *The Remembrance of the Desire of a Soul* (New York, 2000), 249.

symbolically embracing Christ himself.³⁶ As members of the order that St. Francis founded, it is no surprise then that the FMSA Sisters would hold St. Francis as their example. Mother Kevin wrote that leprosy work ‘is our Franciscan Heritage’, and the FMSA missionaries who followed in her footsteps added that ‘we also felt proud that Our Lord had chosen us to be His instruments in fostering this work of charity so dear to the heart of Our Holy Father, St. Francis’.³⁷

Uganda’s missionaries also perceived in leprosy mission a special opportunity to attract Christian converts, in part because in-patient settlements offered the opportunity for sustained contact with potential converts. Unlike other mission enterprises, such as mission hospitals, which patients visited for no more than a few days or a few weeks, leprosy patients often stayed in the settlement for years, usually with extremely limited family contact. The missionaries recognised this sustained contact as a unique opportunity for evangelism. When the CMS Dr. Wiggins first started leprosy treatment in Teso, it was based around five out-patient leprosy centres, where patients would come once a week for treatment. He had some success in evangelising through these centres, but not as much as he had hoped, and Dr. Wiggins wrote that he had ‘much more hope of definite results on the spiritual side once my hospitals are opened’.³⁸ He planned to augment out-patient leprosy treatment with two in-patient hospitals, one for children and one for infectious cases of leprosy, and he hoped that ‘as much Spiritual work will be done in our 2 Hospitals as Medical’.³⁹

Leprosy settlements also drew people into mission contact who otherwise never would have been reached. Many leprosy sufferers travelled great distances to enter a leprosy settlement, especially in the case of the larger CMS settlements, and the missionaries recognised this as an especial benefit of leprosy mission, not only because the leprosy patient

³⁶ C. Peyroux, ‘The Leper’s Kiss’, in L. Little, S. Farmer, and B. Rosenwein (eds.), *Monks and Nuns, Saints and Outcasts* (Ithaca, 2000), 180.

³⁷ ‘Round the Mission’, *Day Star in Africa*, 12 (January 1949), 10.

³⁸ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 1 January 1929.

³⁹ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 9 November 1930.

would be more isolated from the negative influence of their family, but also because ‘many come from districts where that has been no chance of their hearing the Gospel’.⁴⁰ FMSA missionaries were also conscious that leprosy settlements were responsible for bringing new people into contact with the mission, though they were more concerned with winning the souls of leprosy sufferers than using leprosy settlements to gain a greater quantity of Catholic converts.⁴¹

Few available FMSA sources explicitly address the practical aspects of in-patient leprosy settlements that the CMS perceived as uniquely conducive to evangelism, but Catholic missionaries certainly agreed that leprosy mission was an especially effective means of evangelising. CMS Dr. Wiggins wrote that ‘there is no more fruitful field for the Gospel than the work among lepers. Of the seventy recently discharged from Kumi the majority were baptized’.⁴² Similarly, FMSA Mother Kevin wrote that ‘from a spiritual point of view it [leprosy] is by far the most fruitful missionary work in this heathen country’.⁴³ However, Mother Kevin never offered any concrete evidence to support this opinion. Instead, she wrote about the special relationship between leprosy sufferers and Christianity, suggesting that she perceived the fruitfulness of leprosy mission not necessarily in terms of the quantity of Christian converts, but rather in terms of the quality of converts. That being said, it may very well be that the FMSA believed leprosy settlements were effective in gaining larger proportions of converts than other mission efforts. Certainly there was a widespread mission belief in the connection between leprosy and Christianity, and in other parts of the world

⁴⁰ ‘The Healing Fellowship’, *Mission Hospital*, 43.500 (September 1939), 236.

⁴¹ Bishop’s House, Jinja (BH), Nyenga Leper Camp, Letter from Mother Kevin to Father Minderop, 31 May 1933.

⁴² C.A. Wiggins, ‘Retrenchment – and Leper Work’, *Mission Hospital*, 39.445 (February 1935), 34.

⁴³ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’, *The Universe* (19 January 1934).

leprosy settlements were known as small enclaves of Christianity amidst societies largely unmoved by mission evangelism.⁴⁴

Both Protestant and Catholic missionaries believed in a special relationship between leprosy and Christianity, wherein leprosy patients were brought closer to God through their suffering, thereby relieving their suffering and bringing about an especially sincere conversion to Christianity. Missionaries interpreted Christ's instructions to 'cleanse the lepers' as spiritual and physical, particularly before a truly effective biomedical treatment for leprosy was discovered in the late 1940s. Christianity was the only effective treatment that some leprosy patients could hope to receive. Beyond this point, however, Anglican and Catholic theology shaped divergent discussions of Christianity's role in the relief of suffering.

In their Christian leprosy rhetoric, Protestant missionaries focused predominantly on the joy and hope that Christianity could bring to leprosy sufferers while they were alive. As CMS nurse Janet Metcalf wrote:

Though terribly pathetic, it is a wonderful experience to see how some of these suffering lepers hold tight to their faith in the Lord Jesus through their ghastly agony, and the eyes fast becoming sightless will lift up with joy at His name. The terrible neuritic leprosy pain is much more resistant to sedatives than any other form of suffering I have met. Yet if the lepers are Christian they can take it. An atheist writer came to the Island, and when he left he said: "For the first time I have seen some real reason for religion." Truly they are being made perfect through suffering.⁴⁵

Another CMS nurse wrote that 'these poor lepers do indeed come to learn of the Saviour, Who can and does bring joy and peace...into their poor lives, and passing down the wards one sees truly radiant faces, though maimed and scarred by the terrible disease'.⁴⁶ After all, 'God gives a special compensation and consolation to those who suffer', and according to these

⁴⁴ R.S. Kipp, 'The Evangelical Uses of Leprosy', *Social Science and Medicine*, 39.2 (1994), 166-8; J.D. George, "Essentially Christian, Eminently Philanthropic" The Mission to Lepers in British India', *História, Ciências, Saúde—Manguinhos*, 10 (2003), 267.

⁴⁵ University of Birmingham Special Collections (Birmingham), CMS/G3/AL, Janet Metcalf 1947.

⁴⁶ R. Langley, 'Cleanse the Lepers', *Mission Hospital*, 33.431 (December 1933), 314.

missionaries, none suffered more than the leprosy patient.⁴⁷ Joy was brought to the leprosy patient through their knowledge of Christ, and CMS missionaries wrote often of how happy leprosy sufferers were in their Christianity, going so far as to suggest they were lucky to have leprosy, because as some patients said, ‘they can thank God for their leprosy because in it they have found Christ’.⁴⁸ The idea that leprosy sufferers were fortunate in their disease began in the Middle Ages, and was also echoed by Uganda’s Catholic missionaries.⁴⁹ The CMS leprosy rhetoric also discussed the afterlife, but it was through the context of the hope that the idea of Heaven brought into the lives of the suffering. ‘Distorted and disfigured bodies were all forgotten in the joyful anticipation of the new spiritual one which will be given them in the “Great Hereafter”’, for these sufferers had ‘nothing to look forward to until Jesus comes to call them to the land where will be no more pain’.⁵⁰

In discussing the special relationship between leprosy and Christianity, the Catholic rhetoric of leprosy focused especially on preparing leprosy sufferers for life after death. As the Catholic Mother Kevin wrote:

Many of the cases are brought for treatment only when in the worst stages and incurable. The poor victims have nothing to live for in this world, but under the care of the Sisters their great sufferings are relieved, their souls prepared for the Sacraments, and in a few short months they depart for Heaven, comforted and strengthened by the rites of the Church.⁵¹

Such rhetoric was another echo of medieval notions of leprosy, which sometimes painted the ‘leper’ as suffering a living death. Stereotypically, it has been assumed that this living death was a result of the ‘awful disfiguration of the features, festering ulcers on various parts of the body, and in the later stages, pain and insomnia’, but actually this living death was more a

⁴⁷ R. Langley, ‘Report of Happenings among the Lepers’, *Ruanda Notes*, 54 (October 1935), 15.

⁴⁸ Birmingham, CMS/G3/AL Esther Sharp 1946.

⁴⁹ C. Rawcliffe, *Leprosy in Medieval England* (Woodbridge, 2006), 55-64; ‘Namagera Newsreel’, *Day Star in Africa*, 7 (April 1948), 23.

⁵⁰ B. Martin, ‘News of the Lepers’, *Ruanda Notes*, 47 (January 1934), 20; R. Langley, ‘Takes a Bit of Her Holiday to Tell Us of Her Work’, *Ruanda Notes*, 56 (April 1936), 22.

⁵¹ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’.

spiritual matter than a physical one.⁵² Many medieval Christians believed that because the victims of leprosy underwent so much physical suffering during their life, upon their death they would bypass the sufferings of limbo and enter Heaven straightaway.⁵³ As an FMSA Sister wrote of Ugandan leprosy patients, ‘One feels they have entered the antechamber to Heaven’, and of the leprosy settlement at Nyenga: ‘This is the gate of heaven for many a poor soul worn out with life’s battle’.⁵⁴ For sufferers of leprosy to be so close to death, and yet ‘without the grace of Baptism’, was a tragedy.⁵⁵

A partial explanation for the CMS focus on life, as opposed to the FMSA focus on the afterlife, can be found in Protestant and Catholic differentiations in the theology of Purgatory. During the Reformation, the Anglican Church rejected the existence of Purgatory, claiming it had no scriptural basis.⁵⁶ It makes sense, then, that if Catholic tradition saw leprosy sufferers as special for their proximity to Heaven, Catholic missionaries would discuss their preparation of leprosy sufferers for the afterlife, whereas Protestants, who believed all suffering took place in life, would discuss the solace that Christianity could provide to leprosy sufferers during that life.

While the perception of Christianity as the best treatment for leprosy lent justification to the resources that the CMS and FMSA spent on leprosy, both Catholic and Protestant missionaries valued the connection between leprosy and Christianity far more for its effectiveness as an evangelistic tool. All of Uganda’s leprosy missionaries believed that God had a special compassion for leprosy sufferers. The Catholic Mother Kevin wrote that ‘the lepers...seem in a way God’s own special sick children’, while the Protestant Dr. Sharp wrote that ‘the leper appears to be the object of God’s special grace and mercy...as in the days when

⁵² LEPRA Archives, Colchester, England (LEPRA), BELRA Annual Report, 1929, 7.

⁵³ Rawcliffe, *Leprosy in Medieval England*, 57-9.

⁵⁴ ‘Our Least Brethren’, *Day Star in Africa*, 8 (January 1948); St. Francis Leprosy Guild, London, Annual Report, 1940.

⁵⁵ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’.

⁵⁶ Article XII of the Thirty Nine Articles of Religion.

the Lord Jesus was among men.⁵⁷ As ‘special objects of divine compassion’ leprosy sufferers were ‘the first to respond to the Gospel Message, and the first to believe in the Lord Jesus Christ’. Early in the days of leprosy treatment in Kigezi, south-western Uganda, Dr. Sharp wrote that: ‘If our physical results have disappointed us, we have been greatly encouraged by the way in which our lepers respond to the Gospel of Jesus Christ’.⁵⁸ As to *why* God’s special compassion would make leprosy sufferers more likely to convert to Christianity, Protestant missionaries agreed that medical work found ‘special expression in caring for conditions where unusual patience, perseverance, and hope are called for, such as leprosy’.⁵⁹ Victims of leprosy, then, were more likely to convert to Christianity because it could offer them a comfort and hope that no biomedical treatment could yet provide for this chronic and sometimes debilitating disease. Catholic missionaries, too, believed that the suffering of the leprosy patient was what brought them closer to Christ, though as discussed previously, the Catholics perceived this proximity to Christ as a proximity to Heaven, rather than a faith earned through encounters with biblical scripture.⁶⁰

The Christian idea that leprosy sufferers had the innate potential for a special relationship with God because their suffering would draw them to Christianity to find relief, hope, and salvation, was born with the New Testament, and in twentieth-century Uganda culminated in the perception that leprosy patients would be especially sincere converts to Christianity. Missionaries worried about the sincerity of some Ugandan converts to Christianity, suspecting people of being too eager to convert, without fully understanding the enormity of the decision they were making.⁶¹ Leprosy patients offered missionaries a special opportunity to overcome this anxiety over Christian sincerity, for leprosy sufferers were

⁵⁷ Mother Kevin, ‘Work for the Lepers in Uganda,’ *St. Joseph’s Advocate (England)*, 13.9 (1932); L.E.S. Sharp, ‘Work among the Lepers’, *Ruanda Notes*, 23 (January 1928), 9.

⁵⁸ L.E.S. Sharp, ‘Kigezi’, *Mission Hospital*, 264 (May 1928), 104-5; Sharp, ‘Work among the Lepers’, 9.

⁵⁹ *The World Mission of the Church*, 95.

⁶⁰ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’.

⁶¹ Birmingham, CMS/G3/AL Marjorie Atkinson 1931.

supposedly capable of a relationship with God that even European missionaries could not achieve. This idea was born in the Middle Ages: in the twelfth and thirteenth centuries, some perceived leprosy to have a special religious status. When St. Alice the Leper became disfigured through leprosy, and through the disease began experiencing the pains of purgatory, she rejoiced because this suffering brought her to a close relationship with Christ that most Christians could only aspire to.⁶² One CMS missionary wrote that: ‘Their obvious joy and peace, in spite of so much bodily affliction, put me to shame and set me searching to know what was lacking in my own life’, and another that the Christian leprosy patients at Lake Bunyonyi ‘have something really good to teach us... and their keenness will often put us to shame, certainly their ideals too are very high’.⁶³ ‘Weak, feeble, faltering children in Him they may be, but may God always give me their faith’.⁶⁴ This faith was especially valuable because a number of leprosy patients chose to begin evangelising in their own right.

While the FMSA missionaries did not write of their admiration for the Christian faith of their Catholic leprosy patients, they did place a very high premium on the sincerity of the leprosy sufferer’s conversion. When Mother Kevin began Catholic leprosy work in Uganda, she was not merely pursuing another form of mission that she hoped would bring her a greater quantity of Catholic converts. Rather, she wanted *leprosy* converts. When making plans to open a second FMSA leprosy settlement at Buluba, Mother Kevin became concerned that the government would hand over leprosy work in that region to the CMS. She wrote that, ‘If we do not press forward they will take everything from us, and the thousands of lepers will be given over to the Protestants. I am sure God will be with us to avert such a catastrophe’.⁶⁵ For the Catholic missionaries, leprosy sufferers were special, and given the history of inter-denominational competition for converts in Ugandan mission history, several

⁶² Arnold of Villers, *Alice the Leper* (2000), x.

⁶³ E. Longley, *Ruanda Notes*, 78 (February 1942), 6; Birmingham, CMS/G3/AL Grace Mash 1946.

⁶⁴ R. Langley, ‘News of the Lepers’, *Ruanda Notes*, 41 (July 1932), 16-17.

⁶⁵ BH, Nyenga Leper Camp, Letter from Mother Kevin to Father Minderop, 31 May 1933.

Catholic missionaries were anxious that the CMS not be allowed to bring all of these unique potential converts into their leprosy settlements.⁶⁶ For the FMSA, competition was a primary motivation for the foundation of leprosy settlements.

Uganda's Catholic missionaries never wrote of the possibility that a leprosy patient's conversion to Catholicism might not be sincere; FMSA writings presented the leprosy sufferers of Uganda as future Christians who had simply not yet come into contact with God.⁶⁷ While it is possible that the absence of Catholic doubts about the sincerity of a leprosy patient's conversion is due to the comparative dearth of available Catholic sources, if all of the CMS and FMSA's *publications* on leprosy are compared, the Catholic missionaries remain comparatively more likely to assume the sincere conversion of Ugandan leprosy patients. Further unlike the CMS, the FMSA missionaries seem to have valued these conversions solely in and of themselves, for they never wrote of any hopes that leprosy sufferers might in turn evangelise other Ugandans.

Differences in Catholic and Protestant Leprosy Mission in Uganda

In keeping with their differential ideologies of medical mission, the theology of leprosy, and above all the varying resources that they brought to mission, Uganda's Catholic and Protestant missionaries organised their leprosy settlements in different ways. While the CMS and FMSA shared the ultimate goal of using leprosy settlements to evangelise and civilise, they differed in the settlement staffing, size, layout, social organisation, evangelisation, and financial support and expenditure. The remainder of this chapter will explore the differences between the CMS settlements at Lake Bunyonyi and Kumi, and the FMSA settlements at Buluba and Nyenga, focusing especially on their comparative organisation in 1947. In December 1947 and January 1948, Dr. James Ross Innes, the newly appointed Interterritorial Leprologist for East Africa, published detailed reports on his visits

⁶⁶ H.B. Hansen, *Mission, Church and State in a Colonial Setting* (London, 1984).

⁶⁷ Mother Kevin, 'Mother Kevin's Worldwide Appeal for the Lepers'.

to each of Uganda's four leprosy settlements. These four reports, which also coincide in timing with the missions' annual reports for 1947, allow the best grounds for a simultaneous comparison of Uganda's leprosy settlements, given the inconsistencies in each mission's style of reporting and the sources now available.

Staffing

The CMS and FMSA were considerably different in their approach to the staffing of Uganda's leprosy settlements, most notably in their numbers of staff available to manage and serve each leprosy patient, in the duration of missionary appointment at each settlement, and in their reliance on the support of Ugandan staff. The Catholic missionaries focused on maintaining a low ratio of patients to missionaries, relied less upon the assistance and authority of Ugandan staff, and experienced frequent turnovers in missionary staff. The Protestant missionaries relied on an exponentially smaller proportion of British missionaries to manage a larger number of leprosy patients, heavily supported by trained Ugandan personnel and the lengthy experience and tenure of at least one missionary at each settlement. These staffing patterns allowed each mission to pursue their goals for leprosy mission: for the FMSA, a small ratio of staff to patients increased the possibility of moulding and monitoring patients' behaviour, and for the CMS, large leprosy settlements that were able to grow even with a relatively small staff presence.

From their foundation until 1945, the CMS settlements were primarily under the charge of two English female missionaries, with weekly visits from a missionary doctor based at a nearby CMS hospital. The leprosy settlements at Kumi and Ongino had the greatest consistency in its missionary staffing. From 1932 until 1948, CMS nurse Miss Laing was in charge of the settlements, and for eleven of these years she was assisted by another CMS nurse, Miss Kent (see Figure 2). Miss Laing's sixteen-year tenure as head of the Kumi and Ongino settlements allowed the stability for the growth and prospering of the settlements,



Figure 2: 'Childrens Staff', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing. (Front Row: Miss Kent left, Miss Laing right; Back Row Centre: Onesimus)

and when Dr. Innes visited in 1948 he accounted the settlement the largest and the best in East Africa.⁶⁸ It was not until 1948, when Misses Laing and Kent retired, that Kumi faced the debilitating results of drastic staff changes, which had already plagued all of Uganda's other leprosy settlements. Unable to find missionaries to replace Laing and Kent, the CMS began diversifying Kumi and Ongino's European staff, turning to the British Empire Leprosy Relief Association (BELRA) to supply a doctor and an administrative worker, who took up work in 1949.⁶⁹

While the CMS Ruanda Mission's Lake Bunyonyi Leprosy Settlement did not have the benefit of maintenance by a long-term team of CMS missionaries, it grew under the influence of its founding doctor, Leonard Sharp, who visited the settlement weekly between 1931 and 1935, and then was resident from 1942 (see Figure 3). His work was supported by two resident lady missionaries, one of whom had a long tenure on the island. The first such

⁶⁸ UGA, J6/25I, Innes Report 4.

⁶⁹ Birmingham, CMS/G3/A10/1 Subfile 9, Upper Nile Mission.



Figure 3: Left: Dr. Sharp, *Ruanda Notes*, 35 (January 1931); Right: Miss Langley, *Ruanda Notes*, 31 (January 1930).

lady missionary was the nurse Miss Langley, from 1931 to 1937, and the second the teacher Miss Mash, who arrived in 1938. Until Dr. Sharp's return in 1942, these two ladies were assisted by a long string of CMS lady missionaries and visiting doctors, most of whom were English, with the occasional addition of a Scot. The CMS Ruanda Mission had to call on lay societies for European staffing assistance earlier than at Kumi; in 1945, the staff of Lake Bunyonyi was increased and stabilised by the arrival of two nurses who stayed for many years, one sent by the CMS and the other by the British Red Cross.⁷⁰ It was the handful of missionaries stationed at Lake Bunyonyi for several years who created enough stability for the settlement to grow in size, though it never matched the organisation and efficiency of Kumi.

⁷⁰ UGA, J6/25I, Innes Report 5.

Relative to the CMS settlements, the FMSA settlements had a less stable core of mission staff, though they were greater in number, and although more missionaries meant increased contact with individual patients, the comparative instability could also have meant that more Catholic missionaries were needed to undertake the work that fewer CMS missionaries had been able to organise. The FMSA established small convents at each settlement, which housed a handful of European Sisters. Given the relative paucity of administrative records left by the FMSA, it is difficult to be certain of the number and background of the missionaries living in each settlement, but when the settlements opened in 1932 and 1934, each had two resident Sisters, and by 1947, Nyenga had four European Sisters and Buluba six. At the time of Dr. Innes' survey, at least one of the Sisters at each settlement was a trained nurse.⁷¹ Most of the missionary Sisters probably came from two novitiates for Uganda that Mother Kevin established in 1928 and 1935, in England and Ireland respectively. It is likely that a majority of the Sisters were Irish, and the minority English and Scottish, as it was the preponderance of Irish novitiates that motivated Mother Kevin to establish a separate convent in Ireland.⁷²

While it is difficult to be certain of how long each missionary Sister was stationed at each leprosy settlement, remaining correspondence between the colonial government and the Buluba settlement indicates that the superintendence of the settlement passed to a new missionary Sister every three to four years.⁷³ Limited further evidence mentioning the specific names of FMSA missionaries suggests that the majority of the Sisters in each settlement stayed for a space of several years, with only one or two who spent upwards of a decade doing leprosy work. Each settlement was also served by an MHM chaplain, who lived at the nearby MHM mission and spent a portion of his time at the settlement. These MHM chaplains were Irish, Dutch, and English, and between 1932 and 1951, each settlement

⁷¹ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3.

⁷² Sr. Louis, *An Unfinished Canticle*, 69-78.

⁷³ JDA, Medical Leprosy.

was served by no more than two or three chaplains each, suggesting that individual MHM Fathers, at least, had lengthy relationships with each settlement, even though they had little authority.⁷⁴

The two people with the most enduring influence over Nyenga and Buluba were Irish FMSA missionaries Mother Kevin and Dr. Evelyn Connolly, who became Sister Assumpta in 1933. As leader of the FMSA in Uganda, Mother Kevin had responsibilities across eastern Uganda, but she founded both leprosy settlements and remained involved in their maintenance from 1932 until 1943.⁷⁵ Dr. Connolly was never resident at Nyenga or Buluba, but she visited once weekly from Nsambya Hospital whenever another doctor could not be found, which was a frequent occurrence over the years. Sometimes the FMSA could not afford the loss of their hospital doctor or the petrol to travel from Kampala to each settlement, in which case, they made arrangements with the District Medical Officer in Jinja for weekly visits to the settlement.⁷⁶ In 1946, they began hiring lay doctors on short term contract who split their time between Nyenga and Buluba, but Dr. Connolly invariably stepped in as Visiting Medical Officer between each doctor's 12- to 18-month stint, until a long-term contract doctor was finally found in 1951.⁷⁷ Like the CMS, the FMSA relied upon European staff provided by lay organisations. From 1940 to 1942, and from 1947 BELRA supported a lay worker at Buluba who performed such tasks as training leprosy patients in carpentry and hunting the hippos and elephants that regularly destroyed the settlement's crops.⁷⁸

The differential staffing patterns in the Catholic and Protestant settlements take on especial significance when compared to the size of each settlement. The Catholic leprosy settlements had more European missionaries, but fewer leprosy patients. In 1947, for each

⁷⁴ BH, Nyenga Leper Camp, Letter from Father Zuure to Bishop, 17 April 1951.

⁷⁵ FMSA, e. Nyenga, Letter from DMSS to Mother Alcantara, 14 May 1943.

⁷⁶ UGA, J6/11, Letter from DMSS to Chief Secretary, 2 November 1932; UGA, J6/11, Letter from PC Buganda to Chief Secretary, 29 October 1932.

⁷⁷ Dr. Connolly authored many of Nyenga and Buluba's Annual Reports between 1932 and 1951.

⁷⁸ LEPR, W. Lambert, 'My Life with the Lepers', 27; 'Buluba: 50 Years' (1984), 9.

European missionary at Nyenga and Buluba, there were 45 and 36 leprosy patients respectively. Kumi and Ongino and Lake Bunyonyi, on the other hand, had one British missionary per 467 and 176 patients. Catholic and Protestant missionaries alike were assisted in their leprosy work by Ugandan staff, but even with these added personnel, the CMS settlements had far fewer staff to patients in their leprosy settlements. In 1947, each of Uganda's leprosy settlements employed between 19 and 27 Ugandans in full time medical, educational, and administrative work. At Nyenga and Buluba, there were ten leprosy patients per every European or Ugandan staff member, and at Kumi and Lake Bunyonyi there were 53 and 26 respectively.

Most of these Ugandan staff were current or former leprosy patients, who received initial medical or educational training within the settlements. Beyond this, there is little information available about the Ugandan staff of the FMSA leprosy settlements, but the CMS missionaries wrote far more frequently about the staff who assisted them in running Kumi and Lake Bunyonyi. The most influential staff members were the head medical orderlies, who were non-leprosy patients that had received formal medical training at other CMS mission institutions. Secondary in influence were the settlement headmen, who were chosen as responsible Christians by the missionaries, either from the ranks of former leprosy patients, or from outside the settlement altogether. The remaining majority of the Ugandan settlement staff were current or former leprosy patients, trained in medical or educational work during their time at the settlement. For those patients who were deemed particularly responsible, intelligent, and Christian, the CMS offered sponsorship to leave the settlements after leprosy had been arrested, to gain more specialised training as a teacher, nurse, medical orderly, or midwife. Most of these young men and women then returned to one of the leprosy settlements to work. Although the missionaries tried to recruit 'untainted' staff for the settlement, in particular because they hoped for teachers with higher qualifications than

their own leprosy patient teachers, and because they needed ‘untainted’ staff to care for the ‘untainted’ babies of patients, there were never more than a handful of these non-patient staffers present at the CMS settlements, due to the isolation that resulted from living within the confines of the leprosy settlement; the rather unpleasant nature of some of the medical work; and the relatively low rates of pay that the missions could provide.⁷⁹ According to the missionaries, most Ugandans who volunteered to staff the settlements did so because they felt it was their Christian calling.⁸⁰

There are several possible causes for and implications of the higher staff levels at the Catholic leprosy settlements. In general, Catholic missionaries had greater financial resources and a larger pool of missionaries to draw upon, and it may be that the increased ratio of staff to patients at Nyenga and Buluba were a result of the FMSA’s greater resources relative to the CMS, both in terms of supplying missionaries and paying for the employment of missionaries and Ugandans.⁸¹ From the 1920s it was common for the number of Catholic missionary men to outweigh the number of CMS missionaries in any given District.⁸² After decades of financial struggle and slow growth, in the 1930s the FMSA underwent a rapid expansion in their Ugandan mission work and international fundraising deputations. The mission’s resources were severely strained by this decade of rapid growth, so it stands to reason that for the first few years at Nyenga and Buluba, only two FMSA missionaries were assigned to the leprosy settlements, even though the settlements grew far more rapidly than the mission had expected. Growth did not stall until the 1940s, when Uganda’s Catholic missionaries had to take on extra mission work in place of the Italian Verona Fathers and Sisters, who were interned during World War II. Years of political conflict within the FMSA

⁷⁹ R. Langley, ‘Letter’, *Ruanda Notes*, 59 (January 1937), 24; Langley, ‘Cleanse the Lepers’, 314; Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1943.

⁸⁰ E. Sharp, ‘From Mrs. Leonard Sharp’, *Ruanda Notes*, 87 (January 1945), 10; “‘The Healing of His Seamless Dress’: Annual Report Number’, *Mission Hospital*, 41.476 (September 1937), 211.

⁸¹ T.O. Beidelman, ‘Social Theory and the Study of Christian Missions in Africa’, *Africa*, 44.3 (July 1974), 238.

⁸² A.D.T. Tuma, *Building a Ugandan Church* (Nairobi, 1980), 166.

mission, resulting in and following Mother Kevin's resignation in 1942, further dampened the mission's expansion within Uganda, though for the first time the FMSA began sending missionaries to other countries in East Africa.⁸³ The increase in missionary staff at Nyenga and Buluba in the 1940s might thus be understood as a result of the mission's decision to consolidate, rather than expand into new mission stations, as a result of these conflicts. As the FMSA resources increased throughout the 1930s and 1940s, the CMS' resources became ever more strained, to the extent that the Ugandan staff at Lake Bunyonyi went on strike for higher pay in 1949, and the expansion of European staff at Kumi and Ongino and Lake Bunyonyi required assistance from non-mission organisations in Britain.⁸⁴ Clearly, financial resources influenced the number of staff hired to work at Catholic versus Protestant leprosy settlements in Uganda.

The role of financial resources in dictating the staffing of Uganda's leprosy settlements does not, however, preclude the possibility that other factors affected the settlements' staffing. The Catholic leprosy settlements did not have the benefit of long-term, resident missionaries with formal biomedical training, as the CMS did. The FMSA may not have had the same difficulty finding and supporting leprosy missionaries as the CMS, but until 1951 they were unable to find a doctor or nurse who would be resident for longer than a few years. Sister Peter, who lived at Buluba from 1934 until her death in the 1940s, is the only missionary that available sources recognise as having lived at a Catholic leprosy settlement for more than five years, and even though she was most highly praised among the FMSA Sisters at Nyenga and Buluba for her leprosy work, she did not have any formal biomedical training.⁸⁵ The FMSA also seems not to have relied to the same extent as the CMS on the leadership of Ugandan leprosy staff. So it is certainly possible that the relative lack of constancy among missionary staff stationed at Uganda's Catholic leprosy settlements,

⁸³ Sr. Louis, *An Unfinished Canticle*, 69-101.

⁸⁴ Birmingham, CMS/G3/AL Grace Mash 1949.

⁸⁵ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

the absence of regular biomedical advice, and the minimal weight given to the authority of Ugandan staff, meant that a greater number of European missionaries were required in compensation, so that the settlement could run smoothly.

The long-term presence of trained and well-organised staff was essential to Kumi and Ongino's success as a settlement 'quite outstanding in East Africa'.⁸⁶ When Misses Laing and Kent retired at the beginning of 1948, the settlement faltered severely. In less than a year, the in-patient population of the settlement dropped from 905 to 692, dropping below 700 for the first time since 1938. It was only the continued tenure of the head Ugandan medical orderlies, Onesimus Pusimo and Jesse Ndahura, who had been working at Kumi and Ongino since the 1930s, that kept the settlement functioning.⁸⁷ Given how few in number the CMS missionaries were, they had to rely on Ugandans to take on many responsibilities that the Catholic missionaries were able to handle themselves.⁸⁸ This reliance on Ugandan staff allowed for the growth of larger leprosy settlements, even with the involvement of fewer British missionaries. It is also possible that the Catholic missionaries had ideological reasons for ensuring smaller ratios of missionaries to leprosy patients, in terms of promoting social control and evangelisation, which will be discussed later.

The Settlement's Population

Uganda's Catholic and Protestant leprosy settlements were different in the numbers of leprosy patients that they admitted, the Catholic settlements being small and the Protestant settlements being large. One might suppose that greater personnel and financial resources of the FMSA would lead to larger and more efficient leprosy settlements, and as the opposite circumstances proved true in Uganda's leprosy settlements, the small size of Uganda's Catholic leprosy settlements needs particular explanation. It was, after all, the stated goal of

⁸⁶ UGA, J6/25I, Innes Report 4.

⁸⁷ Birmingham, CMS/G3/A10/m1A, Letter from Rev. Calcraft to Hooper, CMS, 17 February 1948.

⁸⁸ Tuma, *Building a Ugandan Church*, 166.

both missions to care for as many leprosy in-patients as possible. CMS missionaries wrote of the segregation of as many leprosy patients as possible as a means of eliminating leprosy in Uganda, as well as alleviating suffering and promoting civilisation.⁸⁹ Uganda's Catholic missionaries also addressed leprosy as a medical problem. When Mother Kevin founded Nyenga and Buluba, she wrote about the high incidence of leprosy in Uganda, and the consequent need for the foundation of more leprosy settlements.⁹⁰ In later years, other FMSA missionaries also lamented the very small portion of Uganda's leprosy patients that they were able to treat and evangelise:

The birth of our leper family must be told...Nyenga...and Buluba...have, during the last fifteen years or so lightened the burden of hundreds of tormented pilgrims and helped many a one to pass in peace through that Gate to eternal life. Yet those hundreds are but a drop in the ocean of the thousands that could be thus helped in body and soul had we the Sisters to care for them and the wherewithal for their support... If 20,000 sounds a lot in dollars what about the 120,000 of lepers in this little part of Africa?⁹¹

Interdenominational competition for converts was another reason to bring as many leprosy sufferers under treatment as possible, and the missionaries wrote with especial triumph of those instances in which they were able to convince Protestant or Catholic leprosy patients to convert to the other denomination. There was even overt hostility between the missions: the FMSA missionaries regularly identified Protestant leprosy patients as 'C.M.S.' in their patient records, and even though the colonial government felt Nyenga and Buluba would benefit if a Catholic Sister was sent to study for Kumi at a time, the FMSA could not be persuaded to follow this recommendation.⁹²

Figure 4 charts the population of each of Uganda's four leprosy settlements on an annual basis. Gaps in the graph indicate years for which population statistics are not available, and the in-patient totals do not include healthy settlement residents, for which

⁸⁹ Kabale District Archive, Kabale, Uganda (KDA), Medical 1930-39, Letter from Sharp to DC Kigezi Rogers, 25 March 1932.

⁹⁰ Mother Kevin, 'Mother Kevin's Worldwide Appeal for the Lepers'.

⁹¹ FMSA, e. Nyenga, The Beginnings of the Congregation of Franciscan Sisters in Uganda and Kenya.

⁹² JDA, Medical Leprosy, Letter from Eastern PC to DMS, 30 November 1946.

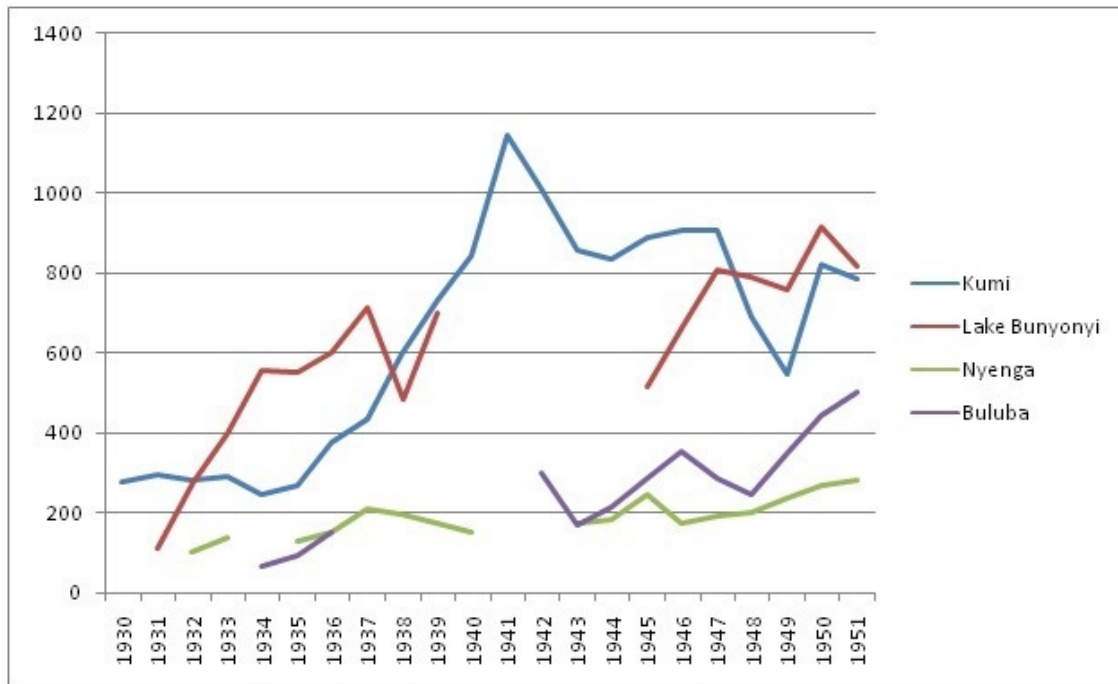


Figure 4: Annual in-patient totals at Uganda's leprosy settlements, 1930-1951

reporting was less regular. As the graph indicates, the CMS leprosy settlements were always larger in size than the Catholic leprosy settlements. From their openings, between 1930 and 1934, until 1951, the average annual population of the CMS leprosy settlements was 638 and 594, while the average population of the FMSA leprosy settlements was 187 and 252. It is also evident from the graph that the population of the Protestant settlements rose and fell more erratically than the Catholic settlements, which was generally a result of staff changeovers or absences. The majority of Kumi and Ongino and Lake Bunyonyi's annual leprosy patient intake resulted from medical safaris that a CMS nurse or doctor made throughout the surrounding area, during which they identified sufferers of leprosy and endeavoured to persuade them to enter the settlement.

The FMSA missionaries, on the other hand, did not undertake medical safaris; instead they relied upon word of mouth and the cooperation of chiefs for patient entry.⁹³ Nyenga and Buluba also admitted patients more selectively, turning away patients instead of

⁹³ This is substantiated by interviews with elderly leprosy patients at Buluba, as well as notes from chiefs introducing new patients, which are attached to many Buluba patient records.

expanding the size of the settlements. Nyenga and Buluba were only 58 kilometres apart, and medically speaking they functioned as two halves of a larger leprosy settlement. In the 1930s and 1940s, the medical community recognised two main types of leprosy, neural and lepromatous.⁹⁴ Nyenga only admitted patients who were diagnosed with neural leprosy: of the 58 leprosy patients that Dr. Innes examined on his visit, 56 were neural cases.⁹⁵ Those who suffered from lepromatous leprosy were transferred annually to Buluba, as Nyenga did not have the space to admit all types of leprosy patients.⁹⁶ Unlike Buluba, which was founded in relative wilderness and was able to make use of 8.5 square kilometres, Nyenga's growth was limited by its location on a smaller plot of land, 0.08 square kilometres in total. With more room for expansion, Buluba was able to receive lepromatous patients who could not be accommodated at Nyenga, and consequently 78 percent of their leprosy patients were lepromatous cases, and 22 percent neural.⁹⁷

Although Buluba had a large area of land upon which to grow, finances and environmental concerns limited the admittance of leprosy patients. Buluba was founded on land that had been cleared for sleeping sickness control in the early twentieth century, and after an outbreak of the disease in 1941, leprosy patients had to be moved off the land again. The mission turned to the government to supply food for patients who were no longer able to cultivate, and this expense caused the Medical Department and District and Provincial administrations to consider moving the leprosy settlement away from Buluba.⁹⁸ Ultimately, opposition from the Basoga Native Administration and inertia on the part of the colonial government led to a decision that the leprosy settlement would remain at Buluba, but in order

⁹⁴ The term 'lepromatous' was associated with more acute cases of leprosy, where higher quantities of the leprosy bacilli were present in the patient and clinical signs were associated with the skin, nose, mouth, and throat. 'Neural' leprosy was considered more chronic and benign, and was associated with patients whose nerves were primarily affected, and whose affected skin showing very little evidence of the leprosy bacillus: L. Rogers and E. Muir, *Leprosy*, 3rd edn (Bristol, 1946), 173.

⁹⁵ UGA, J6/25I, Innes Report 1.

⁹⁶ Interview with Doreen, 26 April 2010.

⁹⁷ UGA, J6/25I, Innes Report 3.

⁹⁸ JDA, Medical Leprosy, Letter from Mother Esther to DC Busoga, 30 July 1941; JDA, Medical Leprosy, Letter from DC Busoga to Kyabazinga, 29 January 1943.

to mitigate the risk of sleeping sickness brought by denser populations, and the expense of supplying food to a large number of patients, the government allowed the mission a larger parcel of land and agreed with the FMSA that Buluba would admit only infectious leprosy patients who were 'likely to benefit from skilled treatment', and their children.⁹⁹ In consequence, all able-bodied and non-infectious leprosy sufferers were discharged from the settlement and returned to their homes, resulting in the sharp drop in patient numbers in 1943.¹⁰⁰

The first matter to consider in explaining why the FMSA treated far fewer leprosy patients than the CMS is whether Catholic missionaries had any ideological predisposition for smaller medical missions. It is difficult to ascertain whether any such ideological considerations impacted upon the FMSA in Uganda, as no evidence remains of their discussion. It is evident, however, that medical mission was less of a priority for the Catholics than for the Protestants, as discussed previously, and moreover that papal injunctions against religious practicing medicine inhibited the growth of Catholic medical mission even after the injunctions were repealed.¹⁰¹ It is also apparent that while practical issues may have hindered Buluba's potential growth, the FMSA also made a choice not to increase the size of their settlements. Certainly the FMSA never had medical aspirations as ambitious as the CMS; they never expressed a desire to house more than 1000 in-patients, whereas the missionaries at Kumi and Ongino hoped to have more than 3000 in-patients.¹⁰² Presumably, if the CMS was able to overcome severe staff and financial shortages to create large leprosy settlements, the FMSA could also have done so, if it was their wish.

⁹⁹ JDA, Medical Leprosy, Busoga Standing Committee on Health, February 1943; JDA, Medical Leprosy, Letter from Eastern PMO to DC Busoga, 29 March 1943; JDA, Medical Leprosy, Memo from DMO Busoga, 16 August 1943; JDA, Medical Leprosy, DC Busoga to Secretary General, 22 September 1944.

¹⁰⁰ JDA, Medical Leprosy, Letter from DC Busoga to Mother Solano, 3 October 1945.

¹⁰¹ J. Manton, 'The Roman Catholic Mission and Leprosy Control in Colonial Ogoja Province, Nigeria, 1936-60', (D.Phil., University of Oxford, 2004), 140.

¹⁰² RCA, Buluba Annual Report 1948; Leprosy Mission, 118/16, M. Laing, 'C.M.S. Leper Home for Children', 12 March 1934.

Physical and Social Organisation

Uganda's Catholic and Protestant missionaries agreed in their desire to create within leprosy settlements a 'model village' where leprosy patients would live 'their usual normal village life, but at the same time...away from the rest of the world'.¹⁰³ Of their Ugandan leprosy settlements, the CMS and FMSA wrote of Lake Bunyonyi and Buluba, respectively, as their greatest successes in creating these model villages. This section will thus focus particularly on the physical and social organisation of these two leprosy settlements in order to examine the different ways that Catholic and Protestant missionaries envisioned and created 'normality'.

In planning and maintaining the settlements at Lake Bunyonyi and Buluba, the CMS and FMSA had different visions of how much land was needed to support model villages, and how that land should be used. While the settlements had similar amounts of land available, 8.4 square kilometres for Bunyonyi and 8.5 square kilometres for Buluba, the amount of land available for each resident was drastically different. Whereas each leprosy patient at Buluba had an average of 31 square metres available, each leprosy patient at Bunyonyi had an average of only 12 square metres available.

The missions also made different use of their allotted land, in accordance with their vision for socially engineering the lives of resident leprosy patients. While Bunyonyi's CMS missionaries chose the layout of the settlement with a view to oversight and convenience, their goal was not to obliterate the 'traditional' Ugandan lifestyle, but rather to integrate it with more 'civilised' and modern British customs. The missionaries took special care to organise the settlement more along the lines of a home than a large institution. The main portion of the CMS leprosy settlement at Lake Bunyonyi was built on Bwama, an island of three square kilometres, with an extra five square kilometres for cultivation on the mainland,

¹⁰³ FMSA, e. Nyenga, Early Days in the Leper Settlements; 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.

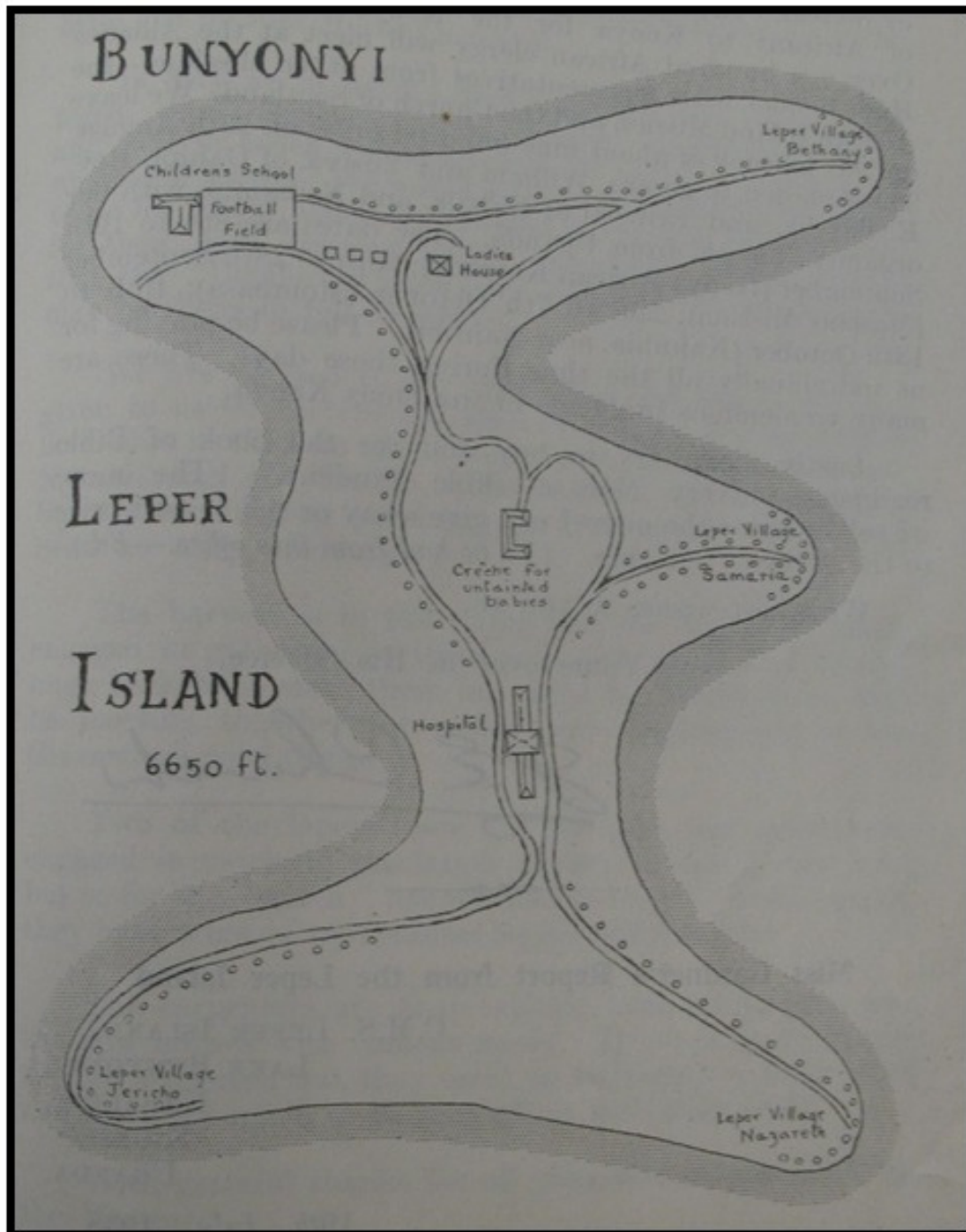


Figure 5: 'The Leper Island. The island itself is called Bwama and it is in Lake Bunyonyi. It is about a mile at its longest length'. *Ruanda Notes*, 65 (August 1938), 21.

an hour's canoe away (see Figure 5). The missionaries used the geographical features of Bwama, its hills and promontories, in order to create different spaces where villages or residences could be established. On promontories at the bottom of each hill were four

villages, which housed leprosy patients based on their degree of infectiousness. Patients built houses along the roads leading to each village, and along the waterfront at the end of each road, and in the centre of the island, were houses for the settlement's Ugandan staff. As nurse Langley wrote: 'Here instead of the usual large institution with its necessary rules and regulations, the separation of the sexes, and all that pertains to a large colony, there is a beautiful island, laid out in villages fringing the lake shore, with the hospital as the central focus'.¹⁰⁴ Another missionary lady wrote:

As far as possible, our people live a normal home life. Married couples have their own houses, and if their children are at a similar stage of the disease as themselves they are with them as well. Single men or women live in houses of four or five together, and we try to mix up the strong and the weak ones together, so that those without hands or feet can be helped by those who are fairly strong. The houses are divided into four villages, under their own council, or lukiko.¹⁰⁵

Two-thirds of the settlement's 'untainted' children remained in their parents' homes. The remaining third lived either in the crèche for 'untainted' babies or were fostered to a non-infectious couple on the island.¹⁰⁶ Marriage and family life were encouraged; two-thirds of the island's adult patients were married. Healthy spouses were also permitted to accompany their relatives to live on Bwama, though as the settlement became more crowded in the 1940s, the missionaries increasingly discouraged this.

At Buluba, the FMSA missionaries spoke of the ideal of creating 'normal' lives for their patients, but in reality it was only men and families who were permitted to live 'their ordinary village life in the attached settlement', whereas single women and children were housed in dormitories on the mission's central plot.¹⁰⁷ As visible in Figure 6, the settlement was then laid out in rectangular partitions divided by roads, with separate sections for girls' dormitories and their school; boys' dormitories and their school; women's dormitories; and a dormitory for infectious male leprosy patients. Married couples and groups of four to five

¹⁰⁴ Langley, 'Cleanse the Lepers', 312.

¹⁰⁵ Birmingham, CMS/G3/AL Janet Metcalf 1946.

¹⁰⁶ UGA, J6/25I, Innes Report 3.

¹⁰⁷ JDA, Medical Leprosy, Letter from Eastern PMO to DMS, 26 August 1941.



Figure 6: Overhead of Buluba, buildings in black are existent, red outlines indicate future building plans, JDA, Medical Leprosy.

unmarried men lived in houses on the edge of the central settlement, with one acre allowed for cultivation.¹⁰⁸ As the settlement grew, it became customary for the mission to grant married couples houses on small plots of land that were increasingly distant from the settlement centre. Such a division was very much at odds with the rhetoric that FMSA missionaries continually espoused in their discussions of Buluba:

The first and most important thing that we try to do with the lepers is to make them feel at home. In all cases their stay will be long and in many permanent. I do not know if people of any race thrive in institutions but certainly Africans do not and it is worse than useless to treat the leprosy of a person when he is eating his heart out for the little grass house in the vast hill-side that is HOME...We must do what we can to make the place as much like a home as possible...These people normally live in small houses in small groups, therefore the dormitory idea is abhorrent to them – except for the children, whose herd instinct is strong, and who, in their own villages tend to get together. Unmarried men, or men who have had to leave their wives at home, live in groups of four or five. Married couples have each their own little house.¹⁰⁹

According to this assessment of the ‘normal’ life of a Musoga, all of Buluba’s leprosy patients, except perhaps children whose parents were not inmates, should be living in small houses rather than large dormitories. How, then, can this difference in practice and rhetoric be reconciled? A possible answer lies in the distinction between allowing leprosy patients the freedom to live a normal life, and exerting enough control to persuade them to lead a moral life.

When Mother Kevin founded Buluba, she wrote that ‘everything possible will be done to make these people useful and happy. Self-supporting and contented, to help them to live their lives in the best possible way’.¹¹⁰ In this article, Mother Kevin does not suggest that her leprosy patients should lead normal lives, but rather that they should lead the *best* lives, and while this distinction was rarely voiced in later writings about Buluba, it offers a possible explanation for the settlement’s organisation. The first concern of the Catholic missionaries was to ensure that the souls of leprosy patients were saved, and in order to find

¹⁰⁸ FMSA, e. Nyenga, Early Days in the Leper Settlements.

¹⁰⁹ FMSA, e. Nyenga, Early Days in the Leper Settlements.

¹¹⁰ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’.

this salvation leprosy patients had not only to be brought into contact with Christian teachings, but also to *live* these Christian teachings. It stands to reason that Catholic missionaries would focus more on living a 'good' life than a 'normal' life, as Catholics believed that it was an individual's actions that determined their salvation, whereas Anglicans believed that the Bible was the basis for salvation. Ensuring that leprosy patients lived moral and Christian lives required close oversight of patients, and this could also partially explain the greater proportion of European missionaries to Ugandan patients at Uganda's Catholic leprosy settlements. It is also worth noting that while the CMS was organised along the lines of group cooperation, the MHM, and potentially other Catholic organisations, were organised around individuals, which supports the speculation that the MHM and FMSA would have wanted closer and more individual contact with leprosy patients.¹¹¹ It may be that the missionaries wished to house unmarried male patients in the same fashion as women and children, but this proved impossible. Numerous visitors to Buluba commented that the missionary ladies had difficulty controlling the behaviour of male leprosy patients, and the missionaries seem to have decided that if they could not force men to live the way that they chose, they could at least settle them on very small plots of land, near the settlement's centre, where oversight would at least be improved.¹¹² It was married couples who were allowed the most freedom, being allotted land and houses and an increasing distance from the settlement's centre as they grew in number.¹¹³ Marriage was not encouraged within the Catholic leprosy settlements: one-third of the women at Buluba lived with their husbands, compared to two-thirds at Lake Bunyonyi. According to the mission, the discouragement of marriage was on medical grounds, but it is worth noting that other Catholic leprosy

¹¹¹ L. Nemer, *Anglican and Roman Catholic Attitudes on Missions* (St. Augustin, 1981), 111.

¹¹² FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

¹¹³ Conversation with Sr. Rosemary Nakahumicha, July 2009.

settlements in Africa preferred to discourage marriage and keep married couples centrally located within the settlement.¹¹⁴

Whereas Uganda's Catholic missionaries endeavoured to influence the behaviour of individual leprosy patients by housing as many as possible in large, centrally located dormitories and ensuring a high staff to patient ratio, the CMS missionaries, who were no less interested in social engineering, endeavoured to promote civilised behaviour through a carefully organised hierarchy that strongly resembled the British colonial government's policy of indirect rule. The CMS missionaries saw the Lake Bunyonyi settlement as: 'a veritable little county, having four villages, Bethany, Samaria, Nazareth, and Jericho. Each village sends its own representatives to the local parliament, which administers the law, settles disputes, and keeps the peace with the aid of the one policeman, himself also a leper'.¹¹⁵ The 'local parliament', or Lukiko, handled most of the day-to-day affairs of the settlement, under the authority of two reliable and Christian Ugandan staffers, the Head Hospital Orderly and the island Chief, who then reported to resident lady missionaries, who in turn answered to the visiting mission doctor. The missionaries even quite literally oversaw the running of their little country: the mission ladies' house was built atop the island's highest hill, 'commanding excellent views'.¹¹⁶

The CMS' dispersal of authority and reliance upon Ugandan staff members to uphold that authority wisely, allowed the creation of a much larger and more efficient leprosy settlement, and the creation of a regulated structure through which the missionaries could intervene into the daily lives of patients without creating disorder. For example, the CMS missionaries at Bunyonyi chose who would live in each of the island's houses, based on their physical ability, ethnic group, and marital state. They were constantly reshuffling the

¹¹⁴ 'Commemorating 25 Years of St. Francis Leper Village', *Day Star in Africa*, 16 (1959), 7; Manton, 'The Roman Catholic Mission and Leprosy Control', 135.

¹¹⁵ L.E.S. Sharp, 'Lake Bunyonyi Leper Colony', *Mission Hospital*, 442 (November 1934), 285.

¹¹⁶ Leprosy Mission, 6/14, L.E.S. Sharp, Report on Leprosy in Kigezi, 15 April 1928.

inhabitants of each house as the settlement's population changed, though patient input was taken into account.¹¹⁷ At Buluba, on the other hand, the lady missionaries and Ugandan headman were remarked upon as unable to exercise adequate control over the leprosy patients, and 'Authority only steps in when it is discovered that one house built to hold six is bulging with a dozen; and that another, equally large, has but one inmate'.¹¹⁸ Personal missionary intervention, it seems, was not necessarily as effective as the interventions of Ugandan staff, and the Catholic missionaries' unwillingness to place great authority and responsibility in the hands of their Ugandan staff may have contributed to their decision not to drastically increase the in-patient numbers at Buluba.

Evangelisation

Catholic and Protestant missionaries had different approaches to Christian evangelisation, and this was as true in Uganda's leprosy settlements as elsewhere. When Dr. Innes undertook his leprosy survey at the end of 1947, he recorded higher rates of conversion at the Catholic leprosy settlements, with 40 percent of Nyenga's patients and 50 percent of Buluba's patients having been baptised Catholic.¹¹⁹ At Lake Bunyonyi, on the other hand, about a third of the patients were baptised Protestants. One explanation for this difference in conversion rates is the way that the CMS and FMSA went about evangelising.

For the CMS, the path to Christianity lay through a thorough understanding of the Bible, and in order to be baptised, leprosy patients had first to learn to read, so that they could read the Bible for themselves. As one CMS reverend in Uganda wrote: 'Education is Evangelisation here'.¹²⁰ In keeping with this requirement, 50 percent of the leprosy patients at Lake Bunyonyi were literate, as compared to a five percent literacy rate in the rest of the

¹¹⁷ Birmingham, CMS/G3/AL, Grace Mash 1945.

¹¹⁸ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938; FMSA, e. Nyenga, Early Days in the Leper Settlements.

¹¹⁹ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3.

¹²⁰ Birmingham, CMS/G3/AL H.T. Wright 1933.

District. Patients could learn to read without converting to Christianity, but given the length of time it took to acquire the skills needed for baptism, it's certainly possible that among the two-thirds who had not been baptised, a number were preparing for it.

For leprosy patients at Buluba or Nyenga, conversion to Catholicism was a quicker matter. Each Catholic mission order varied in their recommendation for the length of the catechuminate, or the years spent preparing for conversion, but in general the recommended length of time was three to four years.¹²¹ In Uganda, however, this length was shortened considerably, as the popularity of Christianity made such a lengthy catechuminate impractical, if not impossible.¹²² At Buluba, most conversions to Catholicism occurred within a year and a half of the patient's arrival, and converts did not have to learn to read before being baptised, which suggests that higher rates of conversion at the Catholic settlements could have been due to greater ease in going through the conversion process.¹²³ In fact, only 15 percent of the leprosy patients at Buluba were literate, though of course this could also have been a disincentive to convert to Catholicism; in late nineteenth-century Busoga the MHM lost many converts to the CMS because the MHM only taught potential converts to know prayers and catechism by heart, rather than being able to read it.¹²⁴ However, interviews with elderly leprosy patients at Buluba and Nyenga, unlike interviews with elderly leprosy patients at Kumi and in Kigezi, suggest that patients who took up residence in the Catholic leprosy settlements felt more compulsion to change their religion.¹²⁵

¹²¹ Nemer, *Anglican and Catholic Attitudes on Missions*, 54.

¹²² A. Shorter, *Cross and Flag in Africa* (Maryknoll, 2006), 142.

¹²³ Many of Buluba's patient records include date of conversion as well as date of entry.

¹²⁴ UGA, J6/25I, Innes Report 3; Tuma, *Building a Ugandan Church*, 65.

¹²⁵ Necessity of converting to Christianity: Interviews with Tom, 22 April 2010 (Buluba); Interview with Demetria, 28 April 2010 (Buluba); Pulekeria, 26 July 2010 (Nyenga); Margaret, 26 July 2010 (Nyenga); Francis, 27 July 2010 (Nyenga); Able to retain another religious denomination: Interviews with Paulo, 7 July 2010 (Kumi); Margaret, 7 July 2010 (Kumi); John, 11 August 2011 (Bunyonyi).

The Finance and Maintenance of Leprosy Settlements

The Catholic and Protestant missionaries received and spent money for their leprosy settlements in different ways, according to their resources and their priorities for the attempted control of leprosy patients. While the FMSA relied more on private donors to finance leprosy settlements that were expensive because central housing was given priority over cultivation, the CMS relied on government grants and British charities to run larger, cheaper, and more self-supporting leprosy settlements. In the first decade of Uganda's leprosy settlements, as measured by financial reports from Kumi, Lake Bunyonyi, and Nyenga in 1938, the difference in total expenditure on each leprosy settlement was not so great. Excluding building projects, which varied greatly during this year, Nyenga and Lake Bunyonyi both spent in the range of 12,500 to 13,200 Ugandan shillings.¹²⁶ However, correlated against the number of patients living in the settlement, the Catholic Nyenga spent 67 shillings per leprosy patient, whereas the CMS Lake Bunyonyi spent 26 shillings per patient. In the 1940s, as the FMSA's resources grew, the difference in expenditure became even greater. In 1947, the CMS spent 53 shillings per patient at Kumi, and 75 shillings per patient at Lake Bunyonyi, while the FMSA spent 193 shillings per patient at Nyenga, and 416 shillings per patient at Buluba.

The primary reason that the FMSA had the resources to spend more money on their leprosy settlements in the 1940s was their wide, international funding base. In 1947, 35 and 49 percent of Nyenga and Buluba's annual funding came from the FMSA mission, whereas only 20 and 1 percent of Lake Bunyonyi and Kumi's annual budget came from the CMS and mission-affiliated donors, though Kumi also received a significant annual grant from the Protestant Leprosy Mission charity.¹²⁷ The remaining finances came primarily from the Ugandan Protectorate government and District Native Administrations, in amounts that

¹²⁶ FMSA, e. Nyenga, Nyenga Annual Report, 1938; KDA, Medical 1930-39, Bunyonyi Annual Report 1948.

¹²⁷ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3; RCA, Bunyonyi Annual Report, 1947; RCA, Kumi Annual Report, 1947.

varied based on the number of leprosy patients in the settlement, their ethnicity, and the relationship between each mission and their respective local government. Overall, the CMS relied more heavily on government grants than the Catholics.

The most significant difference in the annual budgets of the Catholic and Protestant leprosy settlements, which created such a difference in each denomination's spending, was the amount of money spent on the upkeep of each leprosy patient, and specifically on food. Kumi, the largest leprosy settlement in East Africa, grew almost all of its own food and spent only 23 percent of their annual income on patient upkeep, including such items as the purchase of clothing, soap, and oil for lamps, and only three percent of their annual income on food purchases. The Bunyonyi missionaries, who also encouraged their patients to be self-supporting, but who faced more challenges in doing so because of the island's distance from the cultivation plot, spent 43 percent of their annual budget on patient upkeep, and 12 percent on food. On the other hand, the FMSA spent 45 percent of Nyenga's annual income on patient upkeep, and 71 percent on patient upkeep for Buluba, despite the goal for Buluba as a 'model village' where leprosy patients were self-supporting.¹²⁸

The explanation for the amount of money spent on food at Buluba, in particular, lies in the necessity the mission felt to control the movements of its patients. When patients were allowed to spread out across the settlement's land to cultivate in the 1930s, it made the mission's oversight of male patients very challenging, and according to the colonial Medical Department, contributed to the 1941 outbreak of sleeping sickness.¹²⁹ When Buluba was reorganised in 1943, they allowed only one acre of land for each patient, located closer to the settlement's centre, rather than four acres at a further distance. This must have had a deleterious effect on the amount of crops leprosy patients were able to grow, and although there are no precise financial statistics for Buluba before the 1941 outbreak, dozens of pages

¹²⁸ RCA, Buluba Annual Report, 1947; RCA, Nyenga Annual Report, 1947; RCA, Bunyonyi Annual Report, 1947; RCA, Kumi Annual Report, 1947.

¹²⁹ JDA, Medical Leprosy, Letter from DMO Busoga to DC Busoga, 15 July 1943.

of correspondence remain from across the 1940s in which the missionaries at Buluba ask the government for more money for food.

The only other significant variance in expenditure that holds true for all four of Ugandan's leprosy settlements is the FMSA's increased expenditure on European staff salaries and transport. The FMSA missionaries were not paid, but the costs of a lay doctor alone amounted to a greater percentage of the Catholic settlements' annual income in 1947 than the CMS' expenditure on their mission staff. Finally, it can be noted that in general, the CMS spent more money on schooling within their leprosy settlements, which is in keeping with their emphasis on conversion through a literate understanding of the Bible, and the FMSA paid much higher wages to their Ugandan staff, which is consistent with their greater financial resources and location in areas with more stigma against leprosy, which increased the difficulty of finding 'untainted' staff.

Conclusion

Ultimately, Ugandan's Catholic and Protestant missionaries shared the same goal for their leprosy settlements: the evangelisation of leprosy sufferers. However, the CMS and FMSA went about their leprosy mission in different ways, based on their ideologies of medical mission and conversion, their financial and staff resources, and interdenominational competition for converts.

The Church Missionary Society established large leprosy settlements with a small ratio of staff to leprosy patients, and an even smaller ratio of British missionaries to leprosy patients. These settlements were organised upon hierarchical lines that resembled the model of indirect rule used by the British colonial government, in which the CMS missionaries relied heavily upon the cooperation of Ugandan staff and patients in building and maintaining 'model villages'. Leprosy patients were encouraged to be self-supporting and to live in family units, and in combination with the mission's trust in a small cadre of Ugandan staff members,

this allowed the leprosy settlements to grow far larger than the Catholic settlements, albeit with fewer staff and less money. In congruence with the Anglican belief that salvation would be found through the Bible, evangelisation was pursued through teaching leprosy patients to read the Bible, and the CMS settlements placed great emphasis upon education and technical training, supplying most of their own settlement staff and sending many others to work for the colonial government.

The Franciscan Missionary Sisters for Africa, on the other hand, established smaller leprosy settlements with a higher ratio of missionaries and staff to leprosy patients. Given the Catholic Church's belief that salvation was based primarily on an individual's actions, the missionaries took advantage of greater staff numbers to monitor patients' behaviour, relying less on the authority of Ugandans to maintain order in the settlements. Even when granted large tracts of land for the growth of their leprosy settlements, the FMSA missionaries settled all of their leprosy patients within a small area of land, preferring the added expenditure of food provision to allowing patients to cultivate on the fringes of the settlement's land, away from supervision. Medically, the two Catholic settlements functioned together as two halves of a whole, as canon law prohibiting Catholic religious from practicing medicine and surgery hindered the development of Catholic medical mission and created enduring difficulties for the FMSA in Uganda. Yet as different as the Catholic and Protestant leprosy settlements were in some respects, ultimately their shared ideologies of civilisation, evangelisation, and leprosy's relationship with Christianity meant that Uganda's leprosy settlements had more in common than not. The colonial government also shared many of these goals and priorities with the missionaries, as will be discussed in the next chapter.

Chapter 2: Mission and Government Cooperation in Uganda's Leprosy Settlements

Between 1927 and 1934, Christian mission societies opened four large-scale leprosy settlements in Uganda. Ostensibly, these settlements were under the control of the missionaries who ran them, and not the government officials who provided most of the financial support needed to build and maintain them. In reality, several of the missionaries who founded leprosy settlements also fulfilled dual roles as colonial medical officers. As a result, missionary and secular forces were entangled in the provision of medical treatment for leprosy patients in Uganda, and in the funding, administration, and staffing of Uganda's leprosy settlements. Leprosy treatment in Uganda during this time period was thus limited in scope and primarily concerned with palliative care for relatively few in-patients in leprosy settlements, rather than wide-ranging medical treatment for a much larger number of leprosy out-patients.

Early historiography on medicine in British colonial Africa suggests that colonial government and missionary medicine occupied two relatively distinct spheres, and that government officials viewed medical missionaries with suspicion and distrust.¹ British colonial medicine, before the social welfare focus that followed World War II, is characterised as more dehumanising than mission medicine, and concerned primarily with the public health of Africans only insofar as it meant a productive labour force and limiting risk of disease transmission to Europeans. Missionaries, on the other hand, are presented as more concerned with the physical and spiritual welfare of African patients as individuals, rather than as potential sources of labour.²

¹ M. Vaughan, *Curing Their Ills* (Stanford, 1991), 74-5; A. Beck, *A History of the British Medical Administration in East Africa* (Cambridge, 1970), 54.

² For example: J. Comaroff, 'The Diseased Heart of Africa', in S. Lindenbaum and M. Lock (eds.), *Knowledge, Power and Practice* (Berkeley, 1993), 320; C. Good, *The Steamer Parish: The Rise and All of Missionary Medicine on an African Frontier*, (Chicago, 2004), 7; M. Jennings, "'A Matter of Vital Importance': The Place of the Medical Mission in Maternal and Child Healthcare in Tanganyika, 1919-39' in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), 236; T. Ranger, 'Godly Medicine: The Ambiguities of Medical Mission in Southeast Tanzania, 1900-1945', *Social Science and Medicine*, 15B (1981), 261; Vaughan, *Curing Their Ills*, 39.

While the literature does not consider this boundary between secular and mission medicine to be absolute, it also does not appreciate the extent of mission and government cooperation on specific medical issues, even before World War II. The treatment of leprosy, in particular, stands out in more recent scholarship as a health concern that prompted particularly extensive collaboration between colonial government officials and missionaries.³ Yet while these more recent studies recognise a blurring between secular and mission colonial medicine, they still adhere to a paradigm that is characterised by much conflict and suspicion between secular and mission administrators.⁴ This chapter draws on new sources to demonstrate that missions and the colonial government collaborated in the treatment of leprosy in Uganda, and in so doing, shaped a system of medical provision that does not fit within the paradigm of distinct mission and secular colonial medicine in Africa. In addition to CMS and FMSA sources found in the respective missions' archives and headquarters, I analyse reports and meeting minutes found at the National Archive and Rubaga Archive in Uganda. Looking beyond formal and published materials to analyse the day-to-day interactions between and among missionaries and government administrators, I also make use of correspondence found in rarely accessed district archives throughout Uganda.

From the initial mission aspiration to begin large-scale leprosy treatment in Uganda in 1927, government and mission cooperation in the treatment of leprosy outweighed any sense of conflicting medical, social, and political priorities. Government administrators and Anglican British missionaries, in particular, shared a mutual interest in the future of Uganda as a 'civilised', Christianised Protectorate. Whether these government and mission officials were in fact the same person, or whether they merely shared social and religious ties, on a local level, the suspicion and tension that characterised many other interactions between

³ Good, *The Steamer Parish*, 337; J. Manton, 'The Roman Catholic Mission and Leprosy Control in Colonial Ogoja Province, Nigeria, 1936-60', (D.Phil., University of Oxford, 2004), 114-9; S. Shankar, 'Medical Missionaries and Modernizing Emirs in Colonial Hausaland', *Journal of African History*, 48 (2007), 45-68.

⁴ M. Jennings, 'Healing of Bodies, Salvation of Souls': Missionary Medicine in Colonial Tanganyika, 1870s-1939', *Journal of Religion in Africa*, 38 (2008), 37; N.R. Hunt, *A Colonial Lexicon* (London, 1999), 161.

British colonial government officials and missionaries was largely absent in the treatment of leprosy in Uganda. This led to a system of leprosy control that was limited in its scope because it resulted in several large in-patient settlements rather than widespread out-patient dispensaries, and because it was focused as much on the provision of care and charity for vulnerable leprosy patients as it was on the provision of medical treatment.

Mission Priorities for Uganda's Future

When first examining the visions that Uganda's missions and colonial government expressed for the health of Ugandans, it is not difficult to see why much of the historiography on colonial medicine in Africa suggests that missions were primarily concerned with the spiritual health of African patients, while government officials were primarily concerned with their physical health.⁵ CMS missionaries continuously reiterated the importance of evangelism in their leprosy work when they wrote back to their supporters and superiors in Britain. Littering these letters and articles are such statements as: this scheme has been entrusted to the Mission as essentially a missionary enterprise, and the missionary side of the work should be its glory and crown'.⁶ This priority was reflected in correspondence commenting on an article about the Lake Bunyonyi Leprosy settlement in the Uganda Herald newspaper in 1933:

This leper colony was formed with three main ideas, and briefly these are:-

- (1) To protect the general population from infected people and to cause migration;
- (2) To relieve the suffering of the lepers themselves; and,
- (3) To cause the arrest of the disease among children by treatment so as they can live useful lives.⁷

⁵ H.B. Hansen, 'Colonial State's Policy Towards Foreign Missions in Uganda', in H.B. Hansen and M. Twaddle (eds.), *Christian Missionaries and the State in the Third World* (Oxford, 2002); H.B. Hansen, *Mission, Church and State in a Colonial Setting* (London, 1984); U.C. Dirar, 'Curing Bodies to Rescue Souls', in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), 263-5; Good, *Steamer Parish*, 336-7; McCracken, *Politics and Christianity in Malawi, 1875-1940: The Impact of the Livingstonia Mission in the Northern Province* (Zomba, 2000), 197-225.

⁶ Birmingham, CMS/G3/AL Rosa Langley 1933; A.C.S. Smith, 'Leprosy in Kigezi, Uganda Protectorate', *Mission Hospital*, 35.407 (1931), 314.

⁷ 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.

Quoting the article in a letter to CMS headquarters, mission nurse Rosa May Langley appended:

Here I would like to add that first and foremost the Evangelists side has been ~~put first~~ assured. We are absolutely free as far as religious instruction is concerned and have seen real evidences of changed lives and definite conversions with the co-operation of the Holy Spirit...To the Government, General Public naturally the above three points would be the most important but to us of C.M.S., all God's children the extension of His kingdom here on earth is the point that is above all others when considering if the work is worth while or not.⁸

In the words of CMS missionaries, protecting healthy people from leprosy and caring for those already afflicted with the disease were secondary in priority to evangelism. Yet in reality, these goals were part of the same endeavour, and thus the priorities of the mission cannot be so easily ranked by levels of importance.

Benevolence and humanitarianism were also powerful motivations for mission, and in the fulfilment of these goals, as well as that of evangelism, the care of children was particularly important.⁹ Children were believed to be particularly susceptible to leprosy, and thus it was of special importance to protect them from the disease by removing them from leprous parents, or if they had already acquired leprosy, to treat them for the disease in its early stages, so as to increase the likelihood of a future without visible disfigurement.¹⁰ This was as much about welfare as evangelism, as Dr. Wiggins, founder of Kumi Hospital and former CMS missionary asserted:

It is a wonderful work to cut off the entail of a bad past and to give children a real chance. That's child's welfare too. And as regards the leper children—think for example of what is being done at Kumi. The youngest patient there is six weeks old, although the majority of the 200 patients are not so young as that. Think of working

⁸ Birmingham, CMS/G3/AL Rosa Langley 1933.

⁹ A.F. Walls, 'The Heavy Artillery of the Mission Army', in W.J. Shiels (ed.), *The Church and Healing* (Oxford, 1982), 288; P. Williams, 'Healing and Evangelism', in W.J. Shiels (ed.), *The Church and Healing* (Oxford, 1982), 276; 'C.M.S. Medical Missions: VI. Maternity and Child Welfare', *Mission Hospital*, 43.497, (1939), 130-4.

¹⁰ 'CMS Medical Missions: VII. The Care of the Leper', *Mission Hospital*, 43.498 (July 1939), 147; Birmingham, CMS/G3/AL Rosa Langley 1932; C.A. Wiggins, 'Retrenchment', *Mission Hospital*, 39.445 (1935), 34.

for the future there! The majority of those boys and girls will be discharged in a few years symptom free, their lives redeemed from suffering and misery, and the future for most of them is full of brightness and hope. A good deal of the appeal for welfare work is my appeal too.¹¹

In removing children from their homes and families to protect their physical health, there was also a responsibility and an opportunity to protect and promote their spiritual and mental health. Here again, evangelism intertwines with the supposedly secondary priority of causing ‘the arrest of the disease among children by treatment so as they can live useful lives’.¹² In removing children from the supposedly degenerative influence of their ‘primitive’ homes and families, missionaries hoped their teaching and care would ‘leave its mark...upon their lives in future years’, and ‘in a few years to turn out a little band of sincere workers for our Master’.¹³ These children would be all the better for their time in a leprosy settlement, both in their physical and spiritual health and in their ability to spread Christianity and civilisation upon their return home. There was no better evangelist than a cured leper, and while this applied to adults as well as children, children were considered to be particularly impressionable, and thus even better receptacles for the improving graces of civilisation, and when they grew up, better agents in spreading that civilisation and Christianity to the rest of Uganda.¹⁴ Thus in the care of children we see an intersection of the goals of welfare, evangelism, and the civilising mission: goals that were incidentally shared by the British colonial government.

The Origins of Government Interest in Leprosy Treatment

Recent studies on leprosy in Africa have pointed to collaboration between missionaries and colonial governments over the treatment of leprosy. Uganda’s colonial

¹¹ Birmingham, CMS H/H5/E2, Medical Mission Auxiliary Year in Review, 1936-7.

¹² ‘A Leper Settlement on Lake Bunyonyi’, *Uganda Herald*, 28 July 1933.

¹³ L.E.S. Sharp, ‘Kigezi’, *Mission Hospital*, 32.364 (1928), 103; Birmingham, CMS/G3/AL Marjorie Atkinson 1932; Birmingham, CMS/G3/AL Rosa Langley 1931.

¹⁴ R.M. Langley, ‘Letter’, *Ruanda Notes*, 45 (1933), 12; Birmingham, CMS/G3/AL Marjorie Atkinson 1931; Birmingham, CMS G3/AL Ruby Robinson 1931.

government was no exception, being very involved in the Protectorate's leprosy settlements and providing much of their financial support.¹⁵ Yet while the colonial government's commitment to leprosy treatment was enduring, the way in which the government chose to pursue that commitment changed across the first half of the twentieth century with shifts in the resources available, and in external colonial and medical interventions.

In 1927 the secretary of the British Empire Leprosy Relief Association (BELRA), Mr. Oldrieve, visited Uganda in order to complete a survey of leprosy in the Protectorate. BELRA was a secular British leprosy charity, founded in 1923, which published a research journal and offered sizeable grants to leprosy settlements throughout the British Empire. Throughout the 1920s, 30s, and 40s, BELRA occasionally sent officials throughout the British colonies to assess the leprosy situation, in order to stimulate new leprosy work and to gauge how the charity's resources should be spent in the future.

Oldrieve's visit to Uganda marked the first Protectorate-wide attempt to survey the incidence of leprosy and devise a leprosy control policy in the best interests of Uganda's public health. In 1908, when 43 Europeans and Asians staffed 14 native hospitals and dispensaries, only six leprosy patients came to the colonial government's attention, and consequently the Medical Department believed that leprosy was 'rarely met with in this Protectorate'.¹⁶ While the more locally entrenched Catholic White Fathers mission and Native Administrations recognised a higher incidence of leprosy, and starting in the late 1910s they opened a handful of small 'leper camps' across Uganda, their initial purpose was the voluntary housing and segregation of leprosy patients, rather than the provision of medical treatment.¹⁷ It was not until 1926, with 117 Europeans and Asians staffing more than 74 native hospitals, dispensaries, and sub-dispensaries, that Uganda's Medical

¹⁵ Manton, 'Roman Catholic Mission and Leprosy Control', 114-9; Shankar, 'Medical Missionaries and Modernizing Emirs in Colonial Hausaland', 45-68.

¹⁶ Uganda Medical Department Annual Report, 1908, 38, 26, 50.

¹⁷ Uganda Medical Department Annual Report, 1917, 14; Uganda Medical Department Annual Report, 1921, 14.

Department recognised a high enough incidence ‘to warrant special measures of control and treatment’, though they only treated 1000 patients.¹⁸ Further, it was not until Oldrieve’s unsolicited visit in 1927, as part of a global leprosy tour, that colonial medical and administrative officers began to draw up plans for widespread leprosy control.¹⁹ While growing Ugandan government medical staff, resources, and treatment centres led to a corresponding growth in the acknowledgement of leprosy’s incidence, it took the external impetus of an independently-funded leprosy representative to propel Uganda’s colonial government from passive contemplation of widespread leprosy treatment to the formation of a plan of action.

In the aftermath of Oldrieve’s leprosy survey, colonial administrative and medical officers throughout Uganda cooperated in order to use Oldrieve’s recommendations to formulate a policy for leprosy control and eradication that they believed would be most effective in the pursuit of Uganda’s public health. Uganda’s Director of Medical and Sanitary Services (DMSS) perceived segregation as ‘undoubtedly by far the most important measure’ in controlling leprosy, since leprosy was an infectious disease and required an extended course of biomedical treatment.²⁰ The incidence of leprosy could not be decreased unless those who suffered from leprosy could be separated from others during the period that they were infectious. However, compulsory segregation was ‘impossible’: it required a staggering amount of resources, and very few countries chose to spend their money pursuing this method of leprosy control.²¹ Moreover, by the 1920s medical opinion tended towards the idea that compulsion was the worst way to effectively control the spread of leprosy, as it often pushed leprosy sufferers into hiding, where they could spread the disease.²² Within Uganda, it was the locally serving colonial administrative officers who were most insistent

¹⁸ UKNA, CO 685/10, Uganda Medical Department Annual Report, 1926, 12, 49, 98.

¹⁹ JDA, Medical Leprosy, Memorandum from Eastern PC, 23 May 1927.

²⁰ JDA, Medical Leprosy, Letter from DMSS Chell to Eastern PC, 23 January 1927.

²¹ UKNA, CO 685/6, Uganda Medical Department Annual Report, 1923, 7.

²² L. Rogers and E. Muir, *Leprosy*, 3rd edn (Bristol, 1946), 98-100.

about the dangers of compulsory segregation, as for example the Eastern Provincial Commissioner (PC) wrote: ‘Attendance at the Colonies must be entirely voluntary, there must be no harsh compulsion of any kind...if there is any attempt to separate families by force it will quickly lead to the complete dissolution of the whole Scheme’.²³

Recognising that the biomedical treatment of leprosy had to be voluntary and pursued consistently over months, if not years, in order to see a chance of improvement, Uganda’s medical and administrative officers offered a variety of suggestions for leprosy control schemes that would effectively serve the public health of Uganda by treating as many leprosy patients as possible. The earliest ideal for achieving this goal, in 1923, was the establishment of small ‘leper settlements in the proximity of all district sub-dispensaries where the patients can be supervised and receive regular treatment’.²⁴ The colonial government made no effort to achieve this goal, leaving the small work instead to the local Native Administrations and missionaries, but four years later, with Oldrieve’s visit looming, the DMSS expanded upon this plan. It was Oldrieve’s adjustments to this plan that formulated the basis of leprosy policy from 1927 to 1932, during which five years three of Uganda’s five large in-patient leprosy settlements were founded. The Eastern PC summarised these recommendations as:

- (a) Formation main Committee for Protectorate
- (b) Survey made to find out where leprosy work most needed.
- (c) The Provision of a Central Treatment Hospital for each District.
- (d) Treatment at all dispensaries for non-infectious cases. All dressers to have at least one weeks special training in leprosy.
- (e) Exemption from Poll Tax for the year to all who come forward for treatment and obey Medical Officer’s instructions. Exemption only to be granted on production of the certificate from Medical Officer to effect that his instructions have been updated.
- (f) Establishment of leper villages where in these can carry on their life but segregated from the rest of the community.
- (g) Provision for education of children of lepers.
- (h) Educational campaign throughout all schools and addresses in Barazas by District Officers and Medical Officers.
- (i) Growing of *Hydnocarpus Wightiana* and *Hydnocarpus Anthelmintica*, especially in those parts where leprosy most prevalent.

²³ JDA, Medical Leprosy, Letter from Eastern PC to Chief Secretary and DMSS, 23 May 1927.

²⁴ UKNA, CO 685/6, Uganda Medical Department Annual Report, 1923, 7.

(j) Institution of proper funds – Government and Lukiko grants.²⁵

The DMSS agreed with most of Oldrieve's goals for the future of leprosy control in Uganda, and envisioned that the proposed settlements 'should be under the complete control of the Administration', financed and staffed by the colonial and local Ugandan governments.²⁶ Yet while most of these proposals were put into practice in some form over the next five years, the only measures that the central administrative, medical, and agricultural departments took responsibility for were the appointment of a central leprosy Committee, the allotment of colonial government grants, and the importation of the *Hydnocarpus* trees, which provided the specialised medicine for the treatment of leprosy. Setting a pattern for the typical government response to leprosy treatment in Uganda until 1951, the centralised government disbursed those resources that were most effortlessly expended, and passed on the authority and responsibility for leprosy control to the provincial and district administrations, the missions, and local Ugandan governments.

Public Health or Public Good? The Government's Leprosy Policy and its Priorities for Uganda's Future

While the colonial government was professing an interest in instituting leprosy treatment in the Uganda Protectorate, the Church Missionary Society was sending Dr. Wiggins out to Uganda to actually undertake this work. Seven months after Oldrieve's visit to Uganda, Wiggins was in Teso, discussing plans for leprosy treatment with the District Commissioner (DC). The developments in leprosy control policy that occurred on Dr. Wiggins' tour, from 1927 to 1931, furnish an example of the colonial government's early priorities in leprosy treatment.

When Wiggins began his 'experiment in the regular routine treatment of leprosy', he was initially inclined to follow the Medical Department's recommendation to treat leprosy

²⁵ JDA, Medical Leprosy, Memorandum from Eastern PC, 23 May 1927.

²⁶ JDA, Medical Leprosy, DMSS, Report on Leprosy, 1927.

with a segregated in-patient settlement, primarily because it would be less costly in terms of money and staff.²⁷ However, local chiefs and the DC did not believe that segregation was a practicable means of attracting the maximum number of leprosy patients for treatment, and so Wiggins adapted the government's suggestion of treating leprosy patients at dispensaries, not as in-patients who would live in settlements, or 'lines' set up near the sub-dispensaries, but as out-patients.²⁸ If leprosy patients could be treated closer to their homes, one of the greatest concerns of leprosy control policy would be alleviated: persuading leprosy sufferers to segregate themselves for biomedical treatment.²⁹ The first of six out-patient leprosy clinics was opened in August 1928, and utilising a 'mild form of compulsory attendance' to encourage leprosy patients to attend weekly. Within six months the clinics drew more than 2000 patients per week, which amounted to the regular attendance of about 60 percent of the leprosy patients on the doctor's register.³⁰ The foundation of these leprosy clinics was made financially possible by large contributions from the British charities Mission to Lepers and BELRA, and through assistance from the Teso Native Administration.³¹ Although the sanction of Uganda's central government was required for the commencement of the project, they offered no direct financial support for these clinics.

By January 1929, Wiggins had also proposed the founding of an in-patient leprosy settlement for children, as parents were too often 'apt to be slack at bringing them up for treatment'.³² With such staggeringly high numbers of out-patients and an in-patient facility on the horizon, in February 1929, six months after he commenced leprosy treatment in Teso, Wiggins announced that the work had grown too much for one doctor to handle, even with

²⁷ Leprosy Mission, 118/16, Wiggins, The Proposed Anti-Leprosy Campaign in Teso, 1 June 1928.

²⁸ JDA, Medical: Leprosy, Letter from PC Eastern Province to Chief Secretary and DMSS, 23 May 1927; Leprosy Mission, 118/16, Wiggins, The Proposed Anti-Leprosy Campaign in Teso, 1 June 1928.

²⁹ Wiggins, 'Ng'ora', *Mission Hospital*, 32.364 (1928), 106.

³⁰ Birmingham, CMS/G3/AL C.A. Wiggins 1930; J.E.H. Cook, 'Editorial Notes', *Mission Hospital*, 33.376 (May 1929), 104.

³¹ Wiggins, 'Ng'ora', 106-7.

³² Birmingham, CMS/G3/A10/m1A, Wiggins to Hooper, 31 March 1929.

assistance from his nurse daughter and Ugandan orderlies.³³ Wiggins' first hope was that the CMS, supported by the British leprosy charities, could fund another mission doctor for the Teso leprosy work. Although the CMS Medical Committee expressed themselves appreciative of 'the rapid expansion of this work under the supervision and organization of Dr. Wiggins', they did not feel that they were in a position to supply or support another doctor, and moreover: 'leprosy relief work on such a large scale is properly the function of the Government'. They would, however, 'be prepared to encourage a scheme for the development of a Central Leprosy Colony'.³⁴ Although out-patient leprosy treatment was more effective for public health, in-patient leprosy treatment was more effective for evangelism, and the CMS had no qualms about recommending a downsizing of Teso leprosy work, since after all, the public health was the responsibility of the government.³⁵

Dr. Wiggins' last hope was that the government would fulfil their responsibility for the public health of Ugandans by taking over the out-patient leprosy clinics that he had started, leaving in-patient leprosy treatment in the more willing hands of the mission and British charities. However, in a personal meeting, the DMSS told Wiggins that the government could not take over any of the out-patient centres, or provide extra medical staff in Teso. Wiggins concluded that 'the campaign against Leprosy in this district is entirely in our [the mission's] hands and future work must be planned according to the staff at our disposal'.³⁶ Although the central Medical Department would not financially support the recurrent annual cost of out-patient leprosy treatment, they did agree to contribute a special, one-time grant for the foundation of an in-patient leprosy settlement. In light of this projected decrease in out-patient treatment, Wiggins proposed that the government's funds go to the foundation of an in-patient leprosy settlement for infectious adults, while the children's

³³ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 23 February, 1929.

³⁴ Leprosy Mission, 118/16, Letter from J.E.H. Cook to Rev. Syson, 25 April 1929.

³⁵ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 26 April 1929.

³⁶ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 26 April 1929.

leprosy settlement, which was a more attractive fundraising prospect, would be the financial responsibility of the Mission to Lepers and CMS. The out-patient leprosy centres would be reduced in number, and the DC promised funds from the Native Administration for the staffing of these clinics.³⁷ This promise was honoured until 1935, when the Teso missionaries decided that the attendance at the one remaining out-patient clinic was no longer significant enough to justify its expense and staffing burden.³⁸ Thus while the central government preferred to bestow occasional grants for building projects, the local government was far more willing to entertain the thought of annual public health expenses for leprosy.

While Wiggins was planning leprosy control in Teso, two more CMS doctors, Sharp and Stanley Smith, were conceiving plans for leprosy treatment in southwestern Kigezi: a scheme that was surrounded by four years of debate over the most effective way to promote Uganda's public health through treating leprosy. These debates followed similar lines to the nearly simultaneous discussions that guided to the development of leprosy treatment in Teso: compulsory segregation, though desirable, was recognised to be an impossibility, and so government officials and missionaries argued over the most effective means of attracting leprosy patients for treatment. Even while the mission doctors were planning a centralised in-patient leprosy settlement, the District Medical Officer (DMO) was encouraging the routine treatment of leprosy patients at government sub-dispensaries.³⁹ If voluntary segregation was to succeed, the DMO wrote that:

The leper camp must be made so attractive that patients will clamour for admission. The mode of living the food the climate the amusements and chance of [?] etc., must all be far superior to that enjoyed by the natives in their natural habitat, and further more the curative or ameliorative results of treatment in the camp must be so startling as to attract the natives' attention.⁴⁰

³⁷ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 26 April 1929.

³⁸ Leprosy Mission, 118/16, Letter from Rev. Calcraft to Anderson, Secretary, Mission to Lepers, 20 November 1935.

³⁹ KDA, Medical General, DMO Kigezi, Routine Treatment of Leprosy at Sub-Dispensaries, April 1930.

⁴⁰ KDA, Medical General, Letter from DMO Kigezi, 1929.

The creation of such an attractive environment was a difficult prospect even without locating the settlement on an island, and the local district and provincial officers were wary that the island would become ‘an isolation camp round a hospital’ rather than a ‘leper COLONY or settlement’. As Kigezi’s DC wrote: ‘The island...[has] to be reached by water, and this must inevitably give the “patients” a feeling of isolation, or even incarceration; their relatives too would probably discourage such complete segregation.’⁴¹ An earlier Kigezi DC, Captain Philipps, believed that ‘local treatment centres, whether attached or not to existing Dispensaries, would be at first by far the least expensive, the most suitable and, with care, not difficult to popularise’, for young and more easily curable patients would be far more willing to come for regular treatment.⁴² The government’s concern with any flavour of compulsion or incarceration affecting leprosy treatment runs counter to the stereotype that holds governments as more likely to institute harsh leprosy control measures than more benign missions.⁴³ Yet this concern was consistent across Uganda in the early years of leprosy policy planning, and is indicative of the strong emphasis that local administrative officers placed on the value of leprosy treatment as a public health measure, rather than on the idealistic goal of the leprosy settlement as a ‘model village’. If the vast majority of leprosy patients could not be attracted for biomedical treatment, then the entire endeavour for leprosy treatment was ‘foredoomed to failure’.⁴⁴

Although it was almost universally agreed that widespread out-patient treatment would be the most practical and effective means of treating the greatest number of leprosy sufferers, thereby promoting Uganda’s health, this goal had fallen apart by 1931, a mere four years after the colonial government and missionaries began seriously discussing a policy for

⁴¹ KDA, Medical General, Letter from Philipps to Chief Secretary, 23 May 1930; KDA, Medical General, Letter from DC Kigezi to Western PC, 15 May 1930.

⁴² KDA, Medical General, Letter from DC Kigezi Philipps to the Western PC, 24 April 1929; KDA, Medical General, DC’s Office Diary on Leprosy in Kigezi, 1930.

⁴³ Edmond, *Leprosy and Empire* (New York, 2006), 143.

⁴⁴ KDA, Medical General, Letter from DMO Kigezi, 1929.

leprosy control. Wiggins' five out-patient leprosy treatment centres, opened in 1928, were closed in 1929, in favour of the foundation of two centralised, large in-patient leprosy settlements. In Kigezi, the scheme for an island leprosy settlement on Lake Bunyonyi went ahead, in spite of local recommendations for out-patient treatment, and in-patients began arriving there in 1931. Why? While many of Uganda's administrative and medical officers assented to the lofty goals that the DMSS laid out after Oldrieve's visit, there were others who were more realistic about the government's scope to undertake a widespread leprosy control campaign. Early on, in 1927, one PC replied to Oldrieve and the DMSS' suggestions with a detailed plan for leprosy control in the Eastern Province, which if enacted may have been successful, but concluded that:

I consider it to be of the utmost importance to stress the fact that we must be content with small beginnings...it would be better to leave matters as they are rather than to hazard the success of the scheme by starting measures that cannot be continued or carried out to their fulfilment. Any work done must impress the native with its visible success, therefore care must be taken in choosing cases for treatment. Unless these points are borne in mind and unless the matter is approached very carefully the whole scheme will fail from the start and will consequently never be supported by native.

For all that local administrative and medical officers spoke so highly of the efficacy of out-patient leprosy treatment, the central colonial government had neither the resources nor the inclination to support extensive out-patient leprosy treatment.

Though Uganda's colonial government did not support the plan of leprosy treatment that was originally considered most effective in the pursuit of Uganda's public health, they nevertheless provided the majority of the financial support for the four in-patient leprosy settlements opened by missionaries between 1930 and 1934. Upon application, the Protectorate government awarded grants to each settlement annually. While these grants were generally targeted at specific projects within each settlement, they provided a large percentage of the total income. The annual grants for 1947, for Nyenga, Buluba, and Bunyonyi respectively, amounted to a total of £750 (55 per cent of total income), £840 (16

per cent of total), and £1220 (39 per cent of total).⁴⁵ This was out of £3998 pounds spent by the Protectorate on annual grants for leprosy, and £500 in special building grants and amounted to one per cent of the Medical Department's entire annual budget. Yet when the 3000 leprosy patients being treated in these mission institutions are considered against the total number of patients being treated in government medical institutions, 2,293,125, proportionally speaking, they ought to have been receiving only 0.13 per cent of the funding.⁴⁶ Thus the colonial government was spending ten times more money on leprosy than its morbidity statistics would indicate to be appropriate. Moreover, additional government support was forthcoming in the form of Native Administration grants, and support in kind whenever the need arose, from drugs, to Christmas gifts of cattle, to food in time of famine.⁴⁷ Larger Protectorate grants were also regularly awarded for specific building projects; for instance in 1936, the Protectorate provided the settlement at Nyenga with 7,200 pounds for the erection of dormitories and houses.⁴⁸ Thus it is evident, from financial expenditure alone, that the colonial government took an interest in leprosy that was not proportionate to the public health threat that the disease posed, and moreover they spent this money on a plan of leprosy treatment that they were well aware would reach only a fraction of Uganda's leprosy patients.

The effectiveness of centralised, in-patient leprosy treatment continued to be called into question throughout the 1930s and 1940s, only to be dismissed time and again with the assessment that "the future of leprosy control must be left for better times."⁴⁹ These criticisms finally culminated in 1948 with a detailed Uganda leprosy survey by Dr. James Ross Innes, the newly appointed East African Interterritorial Leprologist, who concluded that

⁴⁵ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 4; UGA, J6/25I, Innes Report 5.

⁴⁶ UKNA, CO 685/30, Uganda Medical Department Annual Report, 1947, 55; UGA, J6/25I, Innes Report 12.

⁴⁷ UGA, J6/25I, Innes Report 1; JDA, Infectious and Contagious Diseases, Letter from DC Busoga to Superintendent of Nyenga, 11 December 1948; Birmingham, CMS/G3/AL Grace Mash 1943.

⁴⁸ Bishop's House, Jinja, Uganda (BH), Nyenga Leper Camp, Nyenga Annual Report, 1936.

⁴⁹ JDA, Medical Leprosy, Letter from Eastern PMO to DC Busoga, March 1943.

measures combating leprosy in Uganda were insufficient. He estimated that there were 100,000 cases of leprosy in Uganda, 20,000 of which were highly infectious, and that only 3,000 were receiving treatment in Uganda's leprosy settlements, as in-patients or out-patients.⁵⁰ An additional 689 leprosy patients were treated in government institutions in 1947, and presuming that this rate of treatment continued, in 1948 only 3.7 per cent of the people with leprosy in Uganda were receiving treatment.⁵¹ Innes was blunt in his criticism, noting that the settlements were 'poorly sited strategically', that only eight medically-trained Europeans were actively engaged in leprosy work, and that the new, highly effective sulphone drugs were not being used.⁵² Although Innes' report seemed to surprise and alarm government officials, they cannot have been entirely unaware of the criticisms that he levelled, for most of these concerns had been voiced continuously over the previous two decades.⁵³ Given the disproportionately large amount of money spent treating a small number of patients with leprosy, the strength of Innes' criticisms, and at least a latent awareness of concerns about the effectiveness of leprosy treatment in the Protectorate, it is unlikely that the colonial government's investment in leprosy treatment was primarily an investment in public health. Indeed, the Medical Department spent money and enforced their authority very unevenly across the spectrum of diseases and health problems that afflicted Uganda, often without reference to the actual morbidity and mortality statistics.

The Intersection Between Mission and Government Priorities for the Future of Uganda

Beyond public health, an explanation for the colonial government's investment in the treatment of leprosy in Uganda can be found in the ideologies that government officials

⁵⁰ UGA, J6/25I, Innes Report 12.

⁵¹ UKNA, CO 685/30, Uganda Medical Department Annual Report, 1947, 18.

⁵² UGA, J6/25I, Innes Report 1.

⁵³ UGA, J6/25I, Letter from J.H. Wallace, Entebbe to Potter, Colonial Office, 15 January 1949; DC Busoga 1938 letter.

shared with missionaries: humanitarianism and the civilising mission.⁵⁴ Benevolence was an important aspect of mission, for its own sake and because it might impress those who otherwise would not be swayed by evangelism.⁵⁵ It was also an important motivation for those entering the Colonial Service, particularly doctors, for whom ‘the intrinsically philanthropic nature of the work meant that it was intimately associated with positive ideas of Christian morality’.⁵⁶ Anna Crozier suggests that some individuals joined the Colonial Medical Service because of the perceived link between tropical medicine and religion that had been built by the decades-long presence of medical missionaries in Africa.⁵⁷ Leprosy work was no exception; Dr. Wiggins, the CMS missionary founder of Kumi Hospital, was a retired Colonial Medical Officer of very high standing, and after he retired from medical work altogether, he was ordained and served as a priest in England for two decades.⁵⁸ The appeal of leprosy work was particularly strong for devout Christians, because of its associations with the Bible, but its humanitarian motivations did not have to be explicitly religious. Dr. Sharp, founder of the Lake Bunyonyi leprosy settlement, wrote that, ‘It is the special privilege and joy of the medical work that it meets the need of the down and outs, most wretched and unfortunate of men, women and children’.⁵⁹ Mother Kevin, founder of the leprosy settlements at Nyenga and Buluba, highlighted this aspect of leprosy treatment in her appeal for funds: ‘For the sake of humanity... we appeal to you to send a donation’.⁶⁰ Victims of leprosy were considered to be one of the most unfortunate and vulnerable groups in Uganda, and thus there was great humanitarian benefit in offering ‘lepers’ charity, whether or not that philanthropy was religiously motivated. Humanitarian motivations for service

⁵⁴ A similar point is made by A.K. Tiberondwa, *Missionary Teachers as Agents of Colonialism in Uganda* (Kampala, 2001), 39-44.

⁵⁵ Walls, ‘Heavy Artillery of the Mission Army’, 288; Williams, ‘Healing and Evangelism’, 276; Vaughan, *Curing Their Ills*, 86.

⁵⁶ Crozier, *Practising Colonial Medicine: The Colonial Medical Service in British East Africa* (London, 2007), 59.

⁵⁷ Crozier, *Practising Colonial Medicine*, 60.

⁵⁸ ‘Obituary: C.A. Wiggins’, *British Medical Journal* (5 February 1966), 363.

⁵⁹ L.E.S. Sharp, ‘Dr. Sharp’s Letter’, *Ruanda Notes*, 43 (1933), 27.

⁶⁰ Mother Kevin, ‘Mother Kevin’s Worldwide Appeal for the Lepers’, *The Universe* (19 January 1934).

were increasingly emphasised after World War I, and welfare gained importance in the British colonial agenda after World War II.⁶¹ Thus, colonial government officials considered the care of leprosy sufferers to be a duty, as the deformity of leprosy often led to disability. They also considered it to be an opportunity, as the provision of care for a group of people that Ugandans supposedly refused to support was a justification for colonialism.⁶²

Leprosy settlements were a perfect venue for enacting the ‘civilising mission’, and this was an ideal envisioned by colonial government officials and missionaries.⁶³ Patients in Uganda’s leprosy settlements were removed from their homes and communities for extended periods of time, often with limited contact, and thus the settlements provided missionaries with an atmosphere that was more stable and controlled than in other mission institutions. Missionaries saw in this an opportunity to enact their vision for the future of Uganda, as a ‘civilised’ and Christian country, in the mould of the European countries from which they came.⁶⁴ Uganda’s Protectorate government recognised the potential and benefits of this opportunity for ‘civilising’; the only annual grants that they initially offered each settlement – ones for which there was no necessity for reapplication – were for education.⁶⁵ Officials from the Education Department were sometimes involved in decisions about whether symptom-free leprosy patients were suitable in character and health to go on to outside schooling, even if they planned to enter a mission school.⁶⁶ Missionaries also frequently complained that government hospitals tried to poach medical orderlies that they had trained

⁶¹ F. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London, 1988), 81; Crozier, *Practising Colonial Medicine*, 61; D. Hardiman, ‘Introduction’, in D. Hardiman (ed.), *Healing Bodies, Saving Souls: Medical Missions in Asia and Africa* (Amsterdam, 2006), 20.

⁶² JDA, Medical Leprosy, Letter from Senior Medical Officer, Jinja, to DC Busoga, 26 September 1930; JDA, Medical Leprosy, Memo from DMS Buchanan containing summary of BELRA Meeting Notes from July 1943; Sharp, ‘Kigezi’, 103; Lack of stigma towards leprosy patients: Smith, ‘Leprosy in Kigezi’, 314.

⁶³ T.O. Beidelman, *Colonial Evangelism* (Bloomington, 1982), 21; B. Stanley, *Bible and the Flag* (Leicester, 1990), 157-61.

⁶⁴ UGA, 3993, Letter from Chairman, Uganda Branch BELRA, 2 September 1932; M. Barley, ‘Behold, I Make All Things New’, *Ruanda Notes*, 97 (August 1947), 5; Vaughan, *Curing Their Ills*, 79.

⁶⁵ RCA, Minutes of Uganda’s BELRA Committee Meeting, 8 April 1946.

⁶⁶ UGA, J6/12, Letter from Director of Education to Laing, 15 November 1938.

within the settlements, coaxing them away with offers of better salaries.⁶⁷ The colonial government was not averse to supplying grants if it would mean practical training for Ugandans, who could in turn invest that education in secular as well as mission endeavours.

Another much appreciated aspect of the missions' efforts was the fashioning of leprosy settlements into model communities that conformed to the mission ideal of the integration of 'traditional' Ugandan custom with 'civilisation' and modernity.⁶⁸ The Lake Bunyonyi leprosy settlement, in particular, presented a microcosm of the successes of the civilising mission. It was a regular feature in the tours of Europeans around the area, from King Albert of Belgium, to an American film crew, to a wealth of colonial staff who were sent to Lake Bunyonyi for holiday with the recommendation to spend a day touring the leprosy settlement.⁶⁹ Although leprosy was technically a health problem, Uganda's colonial government took it up as far more than that. It was a humanitarian cause, an opportunity for 'civilising', and a model of the successes of British colonialism. Thus while mission and government goals for the health and future of Uganda might initially appear to be distinct, based on the emphasis in formal publications and letters that missionaries and government officers placed on evangelism and public health respectively, in actuality, missionaries and colonial government officials had much in common, particularly when it came to the treatment of leprosy.

Mission and Government Relations at a Local Level

When it came to the enactment of secular and religious priorities in the practice and policy of leprosy treatment, the level of cooperation and conflict between missionaries and

⁶⁷ R.M. Langley, 'Cleanse the Lepers', *Mission Hospital*, 33.431 (1933), 314.

⁶⁸ Vaughan, *Curing Their Ills*, 79.

⁶⁹ Vaughan, *Curing Their Ills*, 83, 88; L.E.S. Sharp, 'Dr. Sharp's Account of the R.G.M.M. and Leprosy', 6; L.E.S. Sharp, 'Letter', *Ruanda Notes*, 43 (1933), 10; Birmingham, CMS/G3/AL Grace Mash 1949; Interview with Joy Gowers (daughter of Dr. Sharp), 12 February 2010.

government officials was very dependent upon individual personalities and relationships.⁷⁰ Most of the day-to-day affairs of Uganda's 'leper colonies' were settled at the local level. Decisions rested largely in the hands of the small number of European missionaries who were actively involved in each settlement, along with frequent input from the District Commissioner and local Medical Officer. If conflict was a regular feature of mission and government interaction over leprosy, then it is in these local interactions that that conflict would be most apparent. This supposition holds true, not because relations were strained by differing secular and religious priorities, but rather because of the natural tendency for disagreement to appear more readily when the volume of interactions was higher, and the relationships between the individuals closer. This was, however, as valid for agreement as disagreement, and at this local level the European expatriate community was so small that the cultural and social ties uniting the missionaries and government officials tended to outweigh any differences they might have felt due to their religious and secular affiliations. This was particularly true of the British CMS missionaries, who shared religious as well as national and cultural ties with the British Colonial Service. Kabale, for instance, was the centre of the District government and the CMS mission in Kigezi, and while each group was geographically focused around a separate hill, these hills were less than a mile apart, and missionaries shared in the social facilities offered on the government hill.⁷¹ Until the 1940s, the CMS doctors lived in Kabale and travelled to Bwama island several days a week, and the lady missionaries who resided on Bwama travelled to Kabale regularly in turn, to visit with other missionaries and government administrators and their wives, sometimes as often as once a week.⁷² Trips of government officials from Kabale to Bwama were also common, and

⁷⁰ A similar point is made by Manton, 'Roman Catholic Mission and Leprosy Control', 108 and Jennings, 'Healing of Bodies, Salvation of Souls', 34.

⁷¹ Makower, *Not a Gap Year but a Lifetime* (Eastbourne, 2008), 66.

⁷² Interview with Mary Sharp (daughter of Dr. Sharp), 3 November 2009; KDA, Medical 1930-39, Letter from Langley to Switzer, 12 August 1935.

it was very unusual for two months to pass without a visitor.⁷³ Apart from holiday visitors, ceremonial visits from the governor, and inspections, there were individuals like Mr. Masfield, the Kigezi Agricultural Officer in the 1930s, who travelled to the island regularly to run the Boy Scout troop.⁷⁴ Correspondence between CMS missionaries at Kumi and government administrators at Soroti also suggests regular socialisation, though the distance between settlement and government outpost was slightly greater, which meant they were more likely to travel to Soroti for special occasions, such as parties and annual celebrations, as for Empire Day. Thus, while their jobs and ostensible goals during the workday might have been different, missionaries and government officials were united by social and cultural ties.

The practical concerns of leprosy control and maintaining a leprosy settlement brought missionaries and local government officials into even more frequent contact than purely social events. At the very least, the superintendents of Uganda's leprosy settlements were in frequent correspondence with the local DC and DMO, with whom they coordinated a variety of administrative and medical issues. The local colonial administrators were extensively involved in the day to day affairs of each leprosy settlement, and accordingly the District Commissioner's archival records for Teso, Kigezi, and Busoga contain dozens of letters each year sent between various colonial officials and missionaries at Kumi, Lake Bunyonyi, and Buluba respectively.⁷⁵ Local colonial administrators and missionaries were very conscious, therefore, that it was important to build and retain positive relationships. When the CMS sought a replace for Miss Laing as superintendent of Kumi, one mission doctor wrote that: 'The work needs the type...with tact and sweet reasonableness, able to

⁷³ KDA, Medical 1930-39, Letter from Langley to Switzer, 12 February 1935.

⁷⁴ R.M. Langley, 'Report of the Leper Work', *Mission Hospital* 41.479 (1937), 318.

⁷⁵ The District Archives for Buganda, which would refer to the leprosy settlement at Nyenga, are not known to exist.

understand the many problems and discuss matters with senior or junior Government Officials'.⁷⁶

In Teso, the DC frequently acted as a conduit between the missionaries and local Ugandan governments. When child leprosy patients were ready to be released, symptom-free, Kumi's lady superintendent, Miss Laing, would write to the DC with their names and those of their parents, and the DC would then arrange for a letter to be written in Swahili and sent to the parents' local chief, who would in turn inform them that it was time to collect their child. When there was a dispute between relatives of leprosy patients and the missionaries, these relatives would often appeal to the DC, through their local chief, for aid or explanation. Other frequent topics of correspondence included supplementary food deliveries or grants in times of drought or famine; mission requests for the DC's aid in tracking down 'escaped' leprosy patients; and the arrangement of medical safaris on which Miss Laing identified new leprosy patients. Local Native Administrations often paid the bus or taxi fare for arrested leprosy patients from their districts who were ready to return home, and Miss Laing also corresponded extensively with DCs from across northern and eastern Uganda to arrange for this transportation.

Correspondence between the CMS missionaries at Lake Bunyonyi and the colonial officials at Kabale covered a similar range of topics, including discussions of *luwalo* labour being granted by the government for building projects at the leprosy settlement; the adequate supply of food at the local market nearest Bwama island; the transportation of leprosy patients; disputes between the missionaries and former leprosy patients; and mediated contact on behalf of leprosy patients and their former chiefs. The missionaries even called on the government to support them in disputes with leprosy patients. When the settlement's Lukiko, or council, vehemently disagreed with the missionaries' decision that it was unhygienic for

⁷⁶ Birmingham, CMS/G3/A10/m1A, Letter from Dr. E.V. Hunter to Anderson, Secretary, Mission to Lepers, 9 October 1947.

the patients to keep dogs on the island, a missionary appealed to the Kigezi DC for a statement forbidding dogs on Bwama, so that the Lukiko would have more limited grounds on which to negotiate.⁷⁷

Busoga's colonial administrators had an especially close working relationship with the FMSA missionaries at the Nyenga and Buluba settlements, largely because the Catholic mission's limitations of medical staff necessitated greater aid from government medical officers. For example, the mission's difficulties in recruiting a resident doctor for their leprosy settlements, or even in sparing a doctor from Nsambya to travel to the leprosy settlements weekly, meant that they frequently relied upon the Busoga DMO for weekly medical visits to each settlement.⁷⁸ The DMO was based in Jinja, which was 15 kilometres from Nyenga and 42 kilometres from Buluba, so paying for him to travel to the settlements on his days off could be cheaper than doing likewise for a mission doctor from Kampala. Nyenga and Buluba also relied on a government pathologist for their laboratory work until the late 1940s, and admitted severely ill patients to the government hospital in Jinja for treatment when necessary.⁷⁹ Although the greater numbers of missionaries resident at each settlement, and their location near FMSA convents or Mill Hill Mission stations meant that the Catholic missionaries were perhaps more likely to socialise amongst themselves than with local government officials, their reliance on the colonial government for assistance meant that they came into personal contact with colonial officials as frequently, if not more often, than the CMS leprosy missionaries.

The local government, by which I refer to the DC and the Busoga Native Administration, was also heavily involved in the day to day running of Buluba. This relationship was exceptional enough that when the eminent leprologist Dr. Muir visited all of

⁷⁷ KDA, Medical 1930-39, Letter from Langley to Kigezi DC Jenkins, 26 April 1937.

⁷⁸ UGA, J6/11, Letter from DMSS to Chief Secretary, 2 November 1932; UGA, J6/11, Letter from PC Buganda to Chief Secretary, 29 October 1932.

⁷⁹ FMSA, e. Nyenga, Nyenga Annual Report, 1944.

Uganda's leprosy settlements in 1938, he remarked about Buluba that: 'Chief among the disadvantages is the dual form of control by the Administration and the mission'.⁸⁰ The origins of this dual form of control are unclear, though before the settlement was opened, the FMSA and Busoga Native Administration took financial responsibility for the settlement's continued maintenance.⁸¹ While the FMSA had staff available for the settlements, in the 1930s they had very few financial resources for leprosy. The Native Administration therefore took on a disproportionate financial responsibility for Buluba, which may be a reason for the increased involvement of the government in the settlement's maintenance. The involvement of the local government in the administration of Buluba was such that, for example, the FMSA missionaries had to ask the DC's permission to expel a patient for bad behaviour, to compel patients to work, for a non-infectious leprosy patient to stay on living in the settlement, or to change the settlement's official name.⁸² This was in addition to some of the topics of interaction more common between district government officials and missionaries at Uganda's other leprosy settlements, such as tracking down 'escaped' patients and transporting symptom-free leprosy patients back to their homes. Interaction, then, between the Catholic leprosy missionaries and district colonial officials was extensive, and on the surface, always amicable.

Furthermore, in the 1920s the expatriate European community in Uganda was so small in some rural areas that at times, differentiation between secular and mission officials was impossible. Dr. Sharp was both a CMS missionary and the Kigezi District Medical Officer, from 1921 to 1929.⁸³ On the one hand, the Protectorate's central medical staff wanted Sharp to differentiate strictly between his government and mission work, particularly

⁸⁰ FMSA, e. Nyenga, Dr. Muir, Report on Leprosy, 1938.

⁸¹ JDA, Busoga District Annual Report, 1933, 2.

⁸² JDA, Medical Leprosy, Letter from T. Mutaka, County Chief of Butembe Bunya to DC Busoga, 1940; JDA, Medical Leprosy, Letter from DC Busoga to Eastern PMO, 5 April 1940; JDA, Medical Leprosy, Letter from DC Busoga to Sister Felicity, Buluba, 13 April 1945.

⁸³ Makower, *Not a Gap Year*, 53; KDA, Medical General, Letter from Kigezi DMO, 1929; Interview with Joy Gowers, 12 February 2010.

as regarded the financial resources and government sanction that were available to him on his 'medical safaris'. On the other hand, the Provincial Commissioner wrote:

It would not appear possible for Dr. Sharp to draw any dividing line between his Government and Missionary work and as long as the Government employs a half time District Medical Officer, I think it must allow him full discretion over his work.⁸⁴

The District and Provincial officers recognised and accepted that it would be difficult for Sharp to divide his secular and religious work, and moreover that it would be counterproductive for him to try.⁸⁵ Sharp's employment as a government officer and the allowance of 'discretion' over his work is an indication of the close relationship between government and the missions in the 1920s, the minimal British staff levels that would make personal and social relationships between missionaries and government officials more likely, and the trust that the colonial government was putting in the commonality of the goals that they shared with missionaries.

The presence of these shared goals did not prohibit disagreements and frustrations between missionaries and the government, and an exploration of the most prolonged disagreement with respect to leprosy highlights some of the key issues that brought out both tension and agreement between religious and secularly affiliated individuals. Between 1927 and 1929, a spate of letters travelled between five government officials, over whether a leprosy settlement at Lake Bunyonyi was really necessary. In opposition, on grounds that a leprosy settlement was likely to be an ineffective means of combating leprosy in the Kigezi, were the incoming DMO and District Commissioner, the latter who had a previous and not entirely negative relationship with the local missionaries.⁸⁶ In neutral territory was the

⁸⁴ KDA, Medical General, Letter from Western PC Cooper, to Principal Medical Officer, Entebbe, 22 September 1922.

⁸⁵ KDA, Medical General, Letter from Western PC Cooper, to Principal Medical Officer, Entebbe, 22 September 1922.

⁸⁶ KDA, Medical General, Letter from DC Kigezi Philipps to Western PC, 24 April 1929; KDA, Medical General, Letter from DMO Kigezi, 1929; H.B. Hansen, 'The Colonial Control of Spirit Cults in Uganda', in Anderson, D. And D. Johnson (eds.), *Revealing Prophets: Prophecy in Eastern African History* (London, 1995), 156-7.

outgoing DC, who objected only on the grounds that he did not feel that the incidence of leprosy in Kigezi was high enough to warrant a leprosy settlement.⁸⁷ In favour of the settlement were the PC and the DMSS, the former because he felt that ‘the opportunity offered the natives to become cured of this serious disease out-weighs certain sectarian questions which are bound to arise’.⁸⁸ These ‘sectarian questions’, which also concerned the DMSS, pertained to potential conflicts between religious and secular perspectives, and were resolved by the stipulation that government assistance would always be predicated on religious freedom for leprosy patients, before and after admission.⁸⁹ Thus, apart from the question of religious obligation, disagreement was as likely among government officials as it was between the government and missionaries.

Aside from the vagaries of individual opinion, one explanation for differing responses of government officials to a leprosy settlement in Kigezi can be found in their professional ties. Crozier suggests that colonial medical officers in East Africa were united, among other things, by their ties to the profession of medicine, which resulted in a ‘colonial medical identity’ that rose above individual identity.⁹⁰ Apart from the natural identification that came with being in a small minority as white, British, male doctors, these men were also linked, by their training and their work, to a tropical medical community in East Africa. Members of this community went to the same medical schools, followed a similar curriculum in their tropical medical courses in London, used the same tropical medical handbooks, and subscribed to the same medical journals, most notably the *East African Medical Journal*.⁹¹ I argue that, to a certain degree, this colonial medical identity can be extended to the British doctors who were involved in Uganda’s leprosy settlements. Dr. Wiggins, as a former

⁸⁷ KDA, Medical General, Letter from DC Kigezi to Western PC, 24 March 1927; KDA, Medical General, Letter from the DC Kigezi to the Western PC, March 1928.

⁸⁸ KDA, Medical General, Letter from Western PC to the DMSS Keane, September 1928.

⁸⁹ KDA, Medical General, Letter from DMSS Keane to DC Kigezi Philipps, 30 March 1929; KDA, Medical General, Record of meeting on 31 January 1929.

⁹⁰ Crozier, *Practising Colonial Medicine*, 115.

⁹¹ Crozier, *Practising Colonial Medicine*, 119-24; Hardiman, ‘Introduction’, 41-2.

colonial medical officer himself, had strong ties with government-employed medical officers. Dr. Sharp attended medical school at Cambridge before departing for East Africa, as did others who went on to become colonial medical officers in Uganda.⁹² He almost certainly subscribed to the *East African Medical Journal*, and other related medical journals, which would have kept him apprised of developments in the East African medical community, and suggests that missionary and government doctors in Uganda were linked through professional ties.⁹³ Uganda's missionaries and colonial medical officers were also linked into international medical communities; copies of the British *Leprosy Review* journal from the 1930s can still be found in the Soroti District Archive, which served the leprosy settlement at Kumi.

As a result, in the disagreement over the founding of a leprosy settlement in Kigezi, Uganda's colonial medical officers expressed opinions based upon political as much as medical concerns. The DMO did not feel a settlement would be the most effective way to treat leprosy, but while Major Keane, the DMSS, may have shared that personal opinion, he felt politically and professionally bound to act within parameters that other doctors, including mission doctors, would accept to be reasonable, for he was conscious of the ties that Sharp had to influential doctors in England and East Africa. He wrote to the Kigezi DC about the minutes of a recent meeting between the missionaries and government officials, and warned that: 'If the [minute record] reaches Dr. Sharp or Dr. Smith unamended a wrong impression and perhaps misunderstanding might be created and this I am sure you wish to avoid at all costs', particularly because he was sure that 'Dr. Sharp will report to Sir Leonard Rogers on arrival in London'.⁹⁴ Keane's approval was in part motivated by an awareness of the need for professional solidarity, not necessarily because he felt personal ties to Dr. Sharp, but because

⁹² Makower, *Not a Gap Year*, 15; UKNA, CO/685/12, Uganda Medical Department Annual Report, 1928, 121.

⁹³ On mission involvement in the *East African Medical Journal*: E.T.H, 'Editorial', *Ruanda Notes*, 32 (1930), 6; Yolana Pringle, "Feeling 'nervy': Exploring the significance of place and race in cases of mental illness at Mengo Hospital, Uganda, 1897-1940" (paper, African Studies Association Meeting, 21 November 2010).

⁹⁴ KDA, Medical General, Letter from DMSS Keane to DC Kigezi Philipps, 30 March 1929.

Sharp had ties to an eminent doctor in London. Similarly, when plans for the settlement stalled again, Dr. Cook, an influential CMS doctor in Uganda, was asked to write to Keane with a favourable opinion of the scheme in order to move things along.⁹⁵ Thus, through a network of professional and political connections, missionaries working in leprosy settlements were able to prevail upon the government to cooperate in certain ways.

The commencement of leprosy control in Teso is a more straightforward example of the cooperation between local missionary and government officials. Dr. Wiggins, formerly in the Colonial Service himself, wrote very casually of a productive relationship with the DC over the planning of leprosy treatment.⁹⁶ Although his relationship with the Protectorate government was not without frustrations, for instance when he had to wait several months to start his leprosy work because Uganda's recently appointed Leprosy Committee had not yet met, he never wrote with the asperity that CMS missionaries who worked in other parts of Uganda occasionally did, illustrating the important role that personal relationships and professional ties played in determining how conflict between missionaries and government officials played out.⁹⁷ In 1931, Dr. Wiggins and the colonial government fell out over the issue of compulsion in the treatment of leprosy patients, with the government adamantly opposed to it, and Wiggins exhorting that it was essential. Wiggins was most likely incensed because his opinion was being overruled, when only a few years before he had been the Protectorate's highest ranking medical officer, but rather than create direct conflict, he absented himself from all further meetings with the government and resigned his post when the time came for his next home leave, maintaining at least the pretence of civility in all correspondence with the government.⁹⁸

⁹⁵ Birmingham, CMS G3/A7/O, Minutes of a meeting of the CMS Medical Subconference at Mengo Hospital, 7 May 1930.

⁹⁶ Wiggins, 'Ng'ora', 106; Birmingham, CMS/G3/AL C.A. Wiggins 1930.

⁹⁷ Leprosy Mission 118/16, Wiggins, The Proposed Anti-Leprosy Campaign in Teso, 1 June 1928.

⁹⁸ Several letters refer to this incident, from 1930-1931, Leprosy Mission, 118/16.

Although most of Uganda's Catholic leprosy missionaries did not share religious and national ties to the colonial government, their interactions were similarly dependent upon the individual relationships between missionaries and district officers. Some Catholic missionaries may even have shared a closer relationship with government officials than their Protestant brethren, given the close involvement of district administrators and medical officers in the day to day running of Nyenga and Buluba. Historically, Catholic missionaries in Uganda had cause to complain of unfair treatment, but there is no evidence to indicate that any such imbalance in the government's relations between Catholics and Protestants existed in the area of leprosy control.⁹⁹ In fact, the government made a particular effort to ensure equality in leprosy mission, approaching the FMSA to found the leprosy settlements at Nyenga and Buluba even though there were already better trained CMS missionaries willing to take on the work.¹⁰⁰ Although the Medical Department's annual grant to each leprosy settlement was meant to be allocated equally on the basis of how many in-patients each settlement treated, in 1947 Buluba and Nyenga received £3 per patient, while the CMS Lake Bunyonyi received only £1.70 per patient.¹⁰¹ On those occasions that local government administrators did perceive a slight to Catholic leprosy missions, they wrote to the central government on the missionaries' behalf.¹⁰²

Despite such frequent instances of government support, evidence suggests that the Catholic missionaries often perceived slights in their treatment. In Buluba's annual report for 1946, the Sister Superintendent reported the erection of a windmill to pump water from the nearby lake into the settlement and expressed gratitude for 'the Chaplain, who was responsible for the carrying out of this scheme, himself alone, with the aid only of leper boys.

⁹⁹ C. Ferlay, 'Les Pères Blancs et les "Anglais" au Buganda de 1879 à 1929' (Ph.D., Université Paris I Pantheon Sorbonne, 2007), 351.

¹⁰⁰ Mill Hill Mission Archive, Freshfield, England, UGA/24 1932, Letter from Bishop Campling, 9 September 1932; BH, Nyenga Leper Camp, Letter from Mother Kevin to Father Minderop, 31 May 1933.

¹⁰¹ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3; UGA, J6/25I, Innes Report 5.

¹⁰² UGA, 4001, Letter from Acting Eastern PC Kennedy to Chief Secretary, 11 November 1938.

The whole cost of this was borne by the Mission – from Mission Funds'.¹⁰³ Given that each annual report was framed as a request for monetary assistance from the government, these remarks were the pointed product of conflict between Buluba's Catholic missionaries and the Uganda Branch of BELRA. It was quite typical for BELRA's Uganda Branch, with its limited financial resources, to allot half of the funds requested for special building projects, and they did so for Buluba's request.¹⁰⁴ At the same time, they were considerably disconcerted by the mission's unsuccessful attempt to circumvent their authority by appealing directly to BELRA's central office in London, and Buluba's missionaries seemed to perceive this displeasure as the reason only half their grant request was fulfilled.¹⁰⁵ Given that the CMS missionaries had already been unsuccessfully asking for funds to improve their water supply at Ongino for at least three years, such a slight seems unlikely.¹⁰⁶ Indeed, if fewer CMS requests for government aid were refused, it was because the CMS never asked for as much for their leprosy settlements, or because they waited more patiently. It was five years before Uganda's Public Works Department took on the whole cost of installing a running water supply at Ongino.¹⁰⁷

Mission and Government Relations at the Central Level

Wider policy and funding decisions on leprosy control in Uganda were made by members of the Central Committee of the Uganda Branch of BELRA. Most of the money for Uganda's leprosy settlements came from the Protectorate government, and from charities in the UK, such as BELRA and the Leprosy Mission, which were dedicated to combating leprosy worldwide. The Central Committee was largely a forum for the exchange of information between centrally located government officials and missionaries who travelled

¹⁰³ RCA, Buluba Annual Report, 1946.

¹⁰⁴ RCA, Letter from Secretary, Uganda Branch BELRA to St. Francis Leper Village, Buluba, 17 September 1946.

¹⁰⁵ RCA, Letter from Secretary, Uganda Branch BELRA to General Secretary BELRA London, 9 October 1946.

¹⁰⁶ Birmingham, CMS G3/A10/m1A, Kumi Annual Report, 1944.

¹⁰⁷ RCA, Kumi Annual Report, 1948.

from across the Protectorate to be present. As such, the Committee was generally composed of several central Protectorate government officials, including the directors of Medical Services, Education, and African Affairs, highly placed representatives from each of the missions involved, the mission doctor or nurse in charge of each settlement, and one Ugandan representative from a local government. Most of the government's policy and funding decisions for leprosy treatment in Uganda were made beforehand, but the meetings gave all of the people involved in leprosy work across the Protectorate a chance to keep abreast of new developments. Proposals were usually agreed upon unanimously and amicably, and government officials seemed to rely heavily upon the assessments of the missionaries when they made decisions within this setting.¹⁰⁸ The overall picture presented by these Committee meetings, then, was of the central government's disinterest in leprosy control and deference to the expertise of the missionaries.

There were, however, exceptions to the tone of amicability and perfunctory appraisal of each leprosy settlement's annual reports, notably on those occasions were Committee representatives who would, under normal circumstances, be only tangentially included in decisions of leprosy control, used the BELRA meetings as an opportunity to air a personal concern. One such example, as discussed earlier, was the newly-appointed Western PC's objections to the foundation of island leprosy settlement in Kigezi, though the Governor and other local government officials had already consented.¹⁰⁹ A similar incident was when CMS missionary doctor E.V. Hunter was appointed representative for the Upper Nile Diocese (Kumi and Ongino) because none of the missionaries who actually worked at the leprosy settlement could come down to Kampala for the meeting. The Committee's secretary records: 'After-care of crippled lepers-This subject was again raised by Dr. Hunter, in regard to lepers, discharged as "burnt out", who for various reasons had no homes to go to.

¹⁰⁸ RCA, Minutes of Uganda's BELRA Committee Meeting, 19 April 1951; Good, *Steamer Parish*, 340.

¹⁰⁹ KDA, Medical 1930-39, Minutes of Uganda's BELRA Committee Meeting, 6 June 1930.

Discussion on all too familiar lines ensued, as to scope, responsibility, financial burden etc.’¹¹⁰ This unusual reference to an ‘all too familiar’ debate, brought up by a temporary member of the Committee, could point to irritation on the part of more longstanding members of the Committee, particularly as it resulted in the suggestion that counts of each settlement’s ‘burnt-out’ cases be proffered in each settlement’s future annual reports. Such a suggestion could not have been welcome to the Catholic missionaries present, as they had already been disagreeing with the colonial government for years over whether they should be permitted to care for arrested leprosy patients.¹¹¹

What the minute recorder leaves out is that apparently, Dr. Hunter specifically called into question the unnecessary care of ‘burnt-out’ cases at the Kumi and Ongino settlements. This would be in character with Hunter’s rather long history of less than positive interactions with the CMS Teso leprosy settlements, but whereas in the 1940s he normally aired his opinions through the CMS Medical Committee in England, for which he acted as regional medical representative, in this instance he chose the BELRA Committee meeting as a venue, most likely because it had the ear of a number of governmental officials.¹¹² This was probably a source of particular irritation for the Eastern PC, who was the only person present who played an active role in the Teso leprosy settlements. The PC seems to have found Hunter’s concerns and suggestions entirely unnecessary, because he mailed the DMSS an emphatic rebuttal of Hunter’s claims only three days after the Committee meeting.¹¹³ So, the central BELRA Committee meetings could be a venue for individuals who would otherwise have had minimal recourse to express their opinion and agenda, in a setting where it would be heard by highly placed government and mission officials. The missionaries and government

¹¹⁰ RCA, Minutes of Uganda’s BELRA Committee Meeting, 8 April 1946.

¹¹¹ JDA, Medical Leprosy, Letter from DC Busoga to the Secretary General, Jinja, 22 September 1944; JDA, Medical Leprosy, Letter from Sr. Felicity, Buluba, to DC Busoga, 5 December 1945.

¹¹² Birmingham, CMS/M/Y/A10/1, Notes of interview between C.A. Wiggins and CMS Medical Committee, 24 November 1931; Birmingham, CMS/G3/A10/m1A, Letter from Dr. E.V. Hunter to Anderson, Secretary, Mission to Lepers, 9 October 1947.

¹¹³ Soroti District Archives, Soroti, Uganda (SDA), X/NAF/9, Letter from Eastern PC to DMS, 11 April 1946.

officials more directly involved in leprosy work did not need to air any grievances or conflicts at these Committee meetings, for most of leprosy policy was determined within their individual relationships.

One of the reasons for the affability of the government in most of the BELRA Committee meetings, apart from the attitudes and conduct expected of Europeans in Africa, was probably the amount of control that they, or rather their District counterparts, already exercised over the mission leprosy settlements.¹¹⁴ Uganda's central government, represented in leprosy work by the Director of Medical Services and the Director of Education, with occasional input from the Governor and Chief Secretary, was not uninterested in leprosy control; rather they were uninterested in expending the resources necessary to take it on as a real public health measure. They used money and a few key policy decisions to influence the overall development of mission leprosy work in Uganda, while district medical and administrative officials were more heavily involved in the day to day affairs of each settlement. As discussed earlier, government interventions in mission leprosy settlements were commonplace. District and provincial administrators were responsible for a number of the incentives that brought leprosy patients to the settlements for treatment, from poll tax exemption for those who could prove they were receiving biomedical treatment, to instructing local chiefs to send anyone suffering from leprosy to the settlements.¹¹⁵ They were also involved in many smaller ways, such as delineating settlement boundaries, ordering brush clearing, dictating housing terms and agricultural policy, and providing trucks for specific transportation needs.¹¹⁶

The central government controlled how the money that they did expend on leprosy was used by requiring missions to reapply for every grant that they received, except an annual

¹¹⁴ Crozier, *Practising Colonial Medicine*, 124.

¹¹⁵ JDA, Medical Leprosy, Letter from DC Busoga to President of the Busoga Lukiko and DMO Busoga, 3 October 1930; JDA, Medical Leprosy, Letter from Mother Solano to DC Busoga, 9 October 1945; JDA, Medical Leprosy, Letter from DC Busoga, 17 October 1944.

¹¹⁶ JDA, Medical: Leprosy, Letter from DMO Busoga to DC Busoga, 13 July 1943.

grant from the Education Department; by earmarking all of the other grants that they provided, for instance specifying that they be put towards the construction of a particular building; by keeping tabs on the inner workings of the settlements through regular visits and inspections; and by regulating overall funding and leprosy policy.¹¹⁷ Some DCs also asked the missions to account in detail for how each quarterly grant was spent, and indeed a page-long financial return was part of the annual report that each leprosy settlement was required to send in.¹¹⁸ The government was sometimes suspicious of the evangelistic motivations of the missionaries, but instead of producing conflict over this topic, they intervened in ways that could maximise their control over the money that they did spend. Doubtless this was an occasional source of frustration for missionaries, but it was more or less gracefully accepted as a side effect of financial support.¹¹⁹

Less gracefully accepted were the central government's occasional forays into Protectorate-wide leprosy policy, which could completely overturn the missions' policies. One of the earliest examples of such an intervention into leprosy work came in 1929, over the issue of compulsory leprosy treatment. In November 1928, four months after Dr. Wiggins opened his first out-patient leprosy centre in Teso, he instituted 'a very mild form of compulsory attendance' at each clinic.¹²⁰ All leprosy patients who did not attend for weekly treatment without a good excuse were fined, one shilling for their first absence and two shillings for their second absence. If fined patients then regularly attended for three months, their fines were reimbursed. Chiefs decided what circumstances constituted a good excuse, and whether a fine should be levelled, and district officials offered a second opinion while on tour, to make sure that no disabled patients were fined for their immobility. This idea was

¹¹⁷ RCA, Minutes of Uganda's BELRA Committee Meeting, 8 April 1946; 'Annual Report Number', *Mission Hospital*, 42.488 (September 1938), 250; J. Symonds, 'Good News of Kabale', *Ruanda Notes*, 67 (1939), 21; JDA, Medical Leprosy, Letter from DC Busoga Jenkins, to Mother Solano, Buluba, 3 October 1945; Kumi Hospital, Letter from Teso Health Office to Medical Superintendent of Kumi, 16 May 1956.

¹¹⁸ Quarterly expense reports for Kumi and Ongino can be found in the DC's archive in Soroti, Uganda, X/NAF/9.

¹¹⁹ Jennings, 'Healing of Bodies, Salvation of Souls', 50.

¹²⁰ 'Annual Report Number', *Mission Hospital*, 34.391 (August 1930), 181.

formulated by the Teso Leprosy Sub-committee, which included Wiggins, the DC, DMO, a local agricultural officer, three Teso chiefs, and a representative apiece from the local CMS and Roman Catholic missions, and then it was officially sanctioned by the Eastern PC.¹²¹

However, in January 1929 the DMSS overruled the opinion of all the local, district, and provincial officers involved in this out-patient scheme, and objected to the use of compulsion. His objection was based upon the growing medical consensus that compulsion would ultimately be a hindrance to the eradication of leprosy, as it encouraged leprosy sufferers to hide their disease rather than come forward for treatment.¹²² The DMSS took his objection directly to the Governor, and although the Governor had already told chiefs in Teso that he expected them to bring their leprosy patients for treatment, he ruled that 'there should be no compulsion in any shape or form for that is what it comes to'.¹²³ Officially, the decision on compulsion then fell to Uganda's BELRA Committee, but although in discussion several members of the committee were in favour of Wiggins' continuing in his use of compulsory out-patient treatment measures, when it came to a vote, each member felt bound to agree with the Governor's verdict, and opposed compulsion.¹²⁴ From this point onward, in Teso Leprosy Sub-Committee meetings, the district government officials who had originally supported these compulsory attendance measures either absented themselves or abstained from expressing opinions on the matter of compulsion in these meetings, their responsibility to the central colonial government outweighing any personal inclinations they might have on the matter.¹²⁵

The power of the central colonial government to intervene in leprosy policy is particularly evident in consideration of the plethora of reasons that district officials and

¹²¹ Leprosy Mission, 118/16, Agenda, Teso Leprosy Sub-Committee Meeting, 30 May 1929; Leprosy Mission, 118/16, Letter from Wiggins to Secretary, BELRA, 9 January 1929.

¹²² L. Rogers, 'Recent Advances in the Treatment and Prophylaxis of Leprosy', *Leprosy Review*, 1.1 (1930), 21.

¹²³ Leprosy Mission, 118/16, Letter from Wiggins to Secretary, BELRA, 9 January 1929.

¹²⁴ Leprosy Mission, 118/16, Letter from Wiggins to Secretary, BELRA, 9 January 1929.

¹²⁵ Leprosy Mission, 118/16, Agenda, Teso Leprosy Sub-Committee Meeting, 30 May 1929.

members of the BELRA Committee had to support Dr. Wiggins' measures of compulsion. When the Attorney General was consulted on the legal ramifications of compulsory out-patient leprosy attendance, he pointed out that Wiggins was only carrying out the existing Protectorate law on leprosy.¹²⁶ According to the Infectious and Contagious Diseases Ordinance of 1922, compulsory segregation of leprosy patients was allowable, though in 1924 the Governor reported that it was only exercised in townships.¹²⁷ The Medical Department had consciously decided not to enact the legal measures of notification and segregation, due to concerns that 'further antagonism might result amongst the natives' and 'concealment of the disease by large numbers of the population will follow with disastrous results to our chances of combatting this disease'.¹²⁸

Wiggins had ample statistical arguments demonstrating the necessity of compulsion to encourage a large percentage of Teso's leprosy patients to attend for treatment, even before he had to stop the practice of fining. More evidence was supplied in the rapid fall from the treatment of 2400 to 400 patients weekly, directly after fining was rescinded, and the eventual closure of four of the out-patient centres because of no attendance whatsoever.¹²⁹ Iteso chiefs said that if they could not back up their directives to attend out-patient treatment with fines or punishment, 'they will be the laughing stock of the country', and leprosy sufferers would not comply.¹³⁰ Even after the Governor's initial decision against compulsion, Wiggins persisted in his attempts to persuade the Committee to change their ruling, arguing that the Iteso were an exception to the medical rule on compulsion. Their complete indifference to leprosy meant that a fear of stigma would not give them cause to hide their disease from medical authorities, and that compulsion was essential to attract *any* patients, since they would not see

¹²⁶ Birmingham, CMS/G3/AL C.A. Wiggins 1930.

¹²⁷ UGA, A46/2374, Replies to BELRA questionnaire, sent by Governor G.F. Archer on 20 July 1924.

¹²⁸ UGA, A46/2374, Replies to BELRA questionnaire, 20 July 1924; UGA, A46/2374, Letter from Principal Medical Officer to Chief Secretary, 19 March 1925.

¹²⁹ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 17 October 1929.

¹³⁰ Leprosy Mission, 118/16, Agenda, Teso Leprosy Sub-Committee Meeting, 30 May 1929.

the need to treat a disease they didn't even recognise.¹³¹ The Eastern PC supported these points, telling Dr. Wiggins that: 'he had heard no complaint during his tour agreed that no hardship had been inflicted and that no cases have run away or hidden'.¹³² Further agreement was added by visiting expert leprologist Robert Cochrane, who advised on BELRA headquarter's behalf that 'as far as...small fines which were repayable by regular attendance...I cannot, and I am sure my committee agree with me, see why the chiefs should not be allowed to use such measures. This is the association's attitude as far as I can interpret it'.¹³³ Apparently, some leprosy patients even asked for the system of compulsory attendance to be re-introduced.¹³⁴

Unfortunately for the success of Dr. Wiggins' out-patient treatment scheme, none of these arguments was adequate to induce the Committee to change their position, and in March 1930 they reasserted that: 'In the opinion of this meeting the application of legal compulsion in the Protectorate generally for attendance for the treatment of Leprosy not at present desirable', but amended that 'every sort of active persuasion short of legal compulsion is essential for the success of Anti-leprosy measures'.¹³⁵ This 'active persuasion' encompassed a wide range of actions that missionaries, local governments, and district officials pursued in the name of leprosy control over the next twenty years, such as sending police to track down 'escaped' leprosy patients and forcing parents to pay school fees in order to withdraw their children from the leprosy settlements early. Such measures would probably have been termed 'legal compulsion' if the full force of the central Ugandan Protectorate government's scrutiny had been levelled upon them. In most instances, however, the DMSS was content not to know what transpired between the missionaries, chiefs, and district commissioners, intervening to great effect only on select issues.

¹³¹ Birmingham, CMS/G3/A10/m1A, Letter from Wiggins to Hooper, 17 April 1930.

¹³² Leprosy Mission, 118/16, Letter from Wiggins to Secretary, BELRA, 9 January 1929.

¹³³ KDA, Medical General, Robert Cochrane, 'Report on the Leprosy Situation in Uganda', 24 March 1930.

¹³⁴ J.E.H. Cook, 'Editorial Notes', *Mission Hospital*, 34.385 (February 1930), 31.

¹³⁵ KDA, Medical General, Minutes of Uganda's BELRA Committee Meeting, 24 March 1930.

Conclusion

Contrary to the trend of divisiveness between mission and government medicine that has been reported in much of the literature on colonial medicine, in the case of leprosy treatment in Uganda, the distinction between religious and secular practice blurred. At a local level, amicable relationships between individual government officials and missionaries shaped the day to day maintenance of leprosy settlements. At a central level, the Protectorate government and missionaries cooperated to shape the medical and social response to leprosy in Uganda, and this partnership resulted in an approach to leprosy treatment that was atypical of medical missions or government medical centres standing alone. Leprosy control, which offered the possibility of bringing Ugandans into sustained contact with the missions, provided a special opportunity for religious and secular officials to cooperate in the pursuit of the social, economic, and political aims of creating a “civilised” Uganda through engineering model communities.

Despite their concerns for public health in Uganda, mission medical staff and colonial officials allowed concerns of benevolence, religion, resources, and staff to determine a policy towards leprosy control that colonial officials recognised not to be in the best interests of Uganda’s public health. Furthermore, while leprosy may seem the exception to an otherwise practical public health policy, especially in light of the literature on mission and government cooperation of leprosy control in colonial Africa, this paper illustrates the readiness with which government officials departed from the best practice of public health, pointing to the possibility that other diseases, as yet unexplored, received a similarly disproportionate amount of money and attention, perhaps also for the causes of benevolence, religion, and civilisation.

In a country with a history marked by close relationships between missionaries and the colonial government, with few European settlers, and with primarily English-speaking

leprosy missionaries, the secular and religious officials pursuing leprosy control had more in common than not.¹³⁶ These commonalities, and the personal relationships between the individuals involved, as much as the different priorities of the missions and colonial government, shaped the nature of leprosy treatment in Uganda in the 1930s and 1940s, as focused around large in-patient leprosy settlements where the physical, spiritual, and social needs of a minority of Uganda's most vulnerable could be cared for.

¹³⁶ Hansen, 'Colonial State's Policy', 158.

Chapter 3: Catholic and Protestant Conceptions of the ‘Model Village’

In leprosy settlements, Uganda’s missionaries believed they had a special responsibility and opportunity to engineer new lives and communities for leprosy sufferers that would reflect their vision for the future of Uganda as a ‘civilised’, Christian country. Each settlement was to be a ‘model village’, where the best of Ugandan traditions would be integrated with modern British customs. The goal of creating model communities, which would reflect the founder’s vision for progress and ‘civilisation’, was a persistent ideal across colonial and post-colonial Africa, and included such schemes as missionary villages for freed slaves in West Africa, colonial government rural development schemes, colonial sleeping sickness resettlement campaigns, and *ujamaa* villagisation in post-colonial Tanzania.¹ At the root of all of these schemes was the conviction that a handful of ‘civilised’ individuals knew best how to mould the future of many Africans, and this was as true of Uganda’s mission leprosy settlements as of any similar resettlement or development scheme.

This chapter explores the model villages and model lives that Ugandan’s leprosy missionaries endeavoured to shape within leprosy settlements and for leprosy patients. It analyses the responsibilities and opportunities that missionaries of the Church Missionary Society (CMS) and the Franciscan Missionary Sisters for Africa (FMSA) felt towards leprosy sufferers. Leprosy patients were to be transformed from ‘primitive’ and ‘tainted’ Ugandans to ‘civilised’ and healthy men, women, and children with a new life and new community, in Christ and civilisation. Each leprosy settlement was carefully designed to reflect this vision for a ‘civilised’ Uganda, from the site, layout, and construction of the settlement and its buildings to the social, political, and economic organisation and facilities that the

¹ M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, 1991), 79; J. Peterson, *Province of Freedom: A History of Sierra Leone, 1787-1870* (London, 1969); G. Carswell, *Cultivating Success in Uganda: Kigezi Farmers and Colonial Policies* (Oxford, 2007), 59-68; M. Jennings, ‘Building Better People’, *Journal of East African Studies*, 3.1 (2009), 94-111; C. Bonneuil, ‘Development as Experiment’, *Osiris*, 15 (2000), 258-81; J. Weiskopf, ‘Resettling Buha: A Social History of Resettled Communities in Kigoma Region, Tanzania, 1933-1975’, (Ph.D., University of Minnesota, 2011), 94-7; P. Lal, ‘Militants, Mothers, and the National Family’, *Journal of African History*, 51 (2010), 1-20.

missionaries provided. Although leprosy patients played a great role in shaping the reality of their lives in the leprosy settlements, this chapter focuses on the missionaries' visions and plans for their future. The greatest hope of Uganda's leprosy missionaries was that the leprosy sufferers under their care would transcend their 'primitive' Ugandan backgrounds to lead model lives under the healthy, civilised, and Christian influence of the settlements' European and Ugandan staff.

Providing a New Life and Community

Most of Uganda's leprosy missionaries were initially convinced that leprosy was a universally stigmatised disease, and they wanted to rescue leprosy sufferers from the supposed neglect, misery, and stigma that they endured in their homes, and reendow them with humanity through compassion, the introduction of Christianity, and the alteration of their lifestyles. A leprosy sufferer who had not entered a mission leprosy settlement was a 'pathetic derelict of humanity', 'outcasts, uncared for, neglected and the very epitome of misery'.² After entering the settlement, however, they 'were human beings again', by virtue of their 'definite interest in life' and 'will to live'.³ As CMS nurse Langley wrote:

The change in a group of lepers within six weeks after coming to the island is one of God's miracles in the world to-day. To see a human being covered with leprous sores, filthy, vermin ridden, and reduced by suffering and neglect to the state of an animal, raised and restored till he is once again a human being, with a look of hope in his face, is indeed a cause worth looking for.⁴

In the words of a CMS Bunyonyi missionary: 'It is indeed a new life physically: clothes, instead of skins, a healthy house in which to live, plenty of water, and the hope of recovery'.⁵

Life in a leprosy settlement was supposedly transformative for leprosy patients, giving them health, hope, and a reason to live, which in turn justified the missionaries' social engineering.

² Birmingham, CMS/H/H5/E2, Elgon Mission: The Freda Carr Memorial C.M.S. Hospital Ng'ora, 1930, 16; 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.

³ 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.

⁴ R. Langley, 'Cleanse the Lepers', *Mission Hospital*, 33.431 (December 1933), 313.

⁵ M. Barley, 'Behold, I Make All Things New', *Ruanda Notes*, 97 (August 1947), 5.

The formation of a new community, to replace those that had been left behind, was considered an integral part of a leprosy patient's 'new life'. In a 1939 survey of their leprosy work, the CMS quoted a doctor summing up one of the main tasks of the leprosy settlement as:

To deal with that more subtle malady of the leper, the outcast psychology, the bitter anti-social complex, the burning sense of injustice, which inevitably distorts the judgment and darkens the spirit of men and women who, through no fault of their own, have been thrust out of the society of their fellows, branded with the stigma which cannot be hid—to create among these people a sense of community based on some higher loyalty than common suffering or common wrong.⁶

The higher loyalty to which this quote refers is that inspired by Christianity, which the missionaries perceived as integral to community formation within their leprosy settlements. The missionaries believed a sense of community was essential to happiness of individual leprosy patients. As an FMSA missionary wrote of the Catholic leprosy settlements, 'there is a communal life which brings out the best in each one [patient]...isolation as it is practised at Nyenga and Buluba holds no horrors'.⁷

Model Space

Uganda's leprosy missionaries carefully considered the space in which leprosy settlements were located, how they organised the space within the settlements, and how they built each of the settlements' structures. These considerations were in keeping with the different ideas that missionaries had each of Uganda's leprosy settlements for the components that would constitute a 'model village' slightly differently. At Lake Bunyonyi, the term 'model village' was most frequently used in conjunction with descriptions of well-constructed, rectangular buildings that offered family houses and 'all the amenities of native village life', including a hospital, school, playing fields, and space for cultivation and the

⁶ 'C.M.S. Medical Missions', *Mission Hospital*, 43.498 (July 1939), 148-9.

⁷ 'Our Least Brethren', *Day Star in Africa*, 8 (January 1948), 19.

grazing of animals. At Ongino, the CMS missionaries wrote of a 'model village' in terms of the practice of hygiene and the availability of special amenities:

In our teaching of Hygiene and the meaning of good sanitation together with good feeding, we shall, in time, be able to have a Model Leper Village. I have been in touch with the Agricultural Dept. this week, and many seeds have been sent along, for planting trees and also fruit trees. We have also measured out our ground for building a Model Cattle Kraal.⁸

FMSA missionaries never discussed Nyenga in terms of the creation of a 'model village', because its site was too small to allow the construction of houses and adequate fields for family cultivation, but they did refer to Buluba as a 'model village', where families could live in houses, cultivate their own plots, and 'live and work and persevere, and hope for the day when the Doctor will give them the magic ticket which says: "Symptom free."⁹

Locating Leprosy Settlements

In choosing the location each leprosy settlement, the CMS and FMSA missionaries were influenced by the cooperation of the colonial government; practical issues such as land availability, water supply, and ease of transport; and ideological issues such as the former use of the land and the distance from settled populations.

When the CMS and colonial government agreed to begin a leprosy control programme in Teso, they chose the site for the first leprosy settlement because the Uganda Railway agreed to sell them a former railway construction hospital at Kumi, only 18 kilometres from the CMS mission hospital at Ng'ora.¹⁰ In addition to the children's leprosy hospital at Kumi, the CMS also built a hospital for infectious adult leprosy patients at Kapiri, 26 kilometres further away, utilising buildings that were also erected during the construction of the Uganda Railway.¹¹ Four years later, in 1934, they moved the adult settlement to Ongino, because they felt that the site at Kapiri was too far away from Kumi, causing both

⁸ Leprosy Mission, 119/4, Letter from M. Laing, February 1938.

⁹ 'Round the Missions', *Day Star in Africa*, 13 (April 1949), 8.

¹⁰ Birmingham, CMS/G3/A10/m1A, Letter from C.A. Wiggins to Hooper, 31 March 1929.

¹¹ Leprosy Mission, 118/16, Teso Leprosy Sub-Committee Report, 30 May 1929.

expense and inconvenience for the staff who had to travel between the two and the strain of family ties between children and parents who had leprosy. They also believed the Kapiri site to be unhealthy, because of the incidence of malaria and a poor layout.¹² The Ongino site, on the other hand, was only five kilometres away from Kumi, though it did not have the advantage of a water supply, which proved problematic as the settlement grew in size.

The site for Kigezi's leprosy settlement, which was a satellite of the CMS hospital at Kabale, was an issue of intense debate. Ruanda Mission CMS Drs. Sharp and Stanley Smith wanted to situate the settlement on Bwama Island in Lake Bunyonyi, but several colonial government administrators and British humanitarian organisations disliked the idea of situating the leprosy settlement on an island. In addition to the extra expense and difficulty of maintaining an island settlement, the scheme's opponents were concerned that such geographical isolation would discourage leprosy patients from entering the settlement voluntarily.¹³

However the CMS retained a strong ideological attachment to the Bwama island site, for four reasons: an island settlement would increase the isolation of leprosy patients and hopefully facilitate the formation of a new, self-contained community; it was based on the model of island leprosy settlements that had gone before, such as Robben Island in South Africa and Molokai in Hawaii; the site was beautiful; and Bwama had a former reputation as a centre for witchcraft. Before the settlement was opened Dr. Sharp wrote several times of the island's beauty: 'I need hardly say that Bugama [Bwama] Island is a beautiful spot, it is more than that, its views in all directions are exquisite, and I propose to do all I can to make the island a beautiful home for all those who will live there'.¹⁴ A visitor wrote that 'It is not possible to adequately describe the beauties of Lake Bunyonyi in cold prosaic print, but suffice it to be said that the beauty and enchantment of the lake must add effectively to the

¹² UGA, 3993, Letter from Chairman, Uganda Branch BELRA, 2 September 1932.

¹³ Leprosy Mission, 6/14, Letter from Leprosy Mission General Secretary to Webster, 18 June 1928.

¹⁴ L.E.S. Sharp, 'Account of the R.G.M.M. and Leprosy', *Ruanda Notes*, 26 (October 1928), 5.

peace and happiness of those who dwell around it'.¹⁵ Dr. Sharp also relished the idea of locating the Christian leprosy settlement on a site that had been associated with the Nyabingi movement, and thus some of the more undesirable aspects of 'traditional' Ugandan culture:

This island was formerly associated with witchcraft and rebellion, and has long been uninhabited, a wild and beautiful spot, with ample room not only for a leper hospital and staff houses, but also for model villages where leper families can settle and grow their crops while living within easy reach of treatment.¹⁶

Several years later, a CMS missionary lady added: 'This Island which was the home of one of the most powerful witch-doctors (and on whose domain our home is built) a few years ago – is now the home of Lepers under Christian influence and what was once a wild waste is now field its' fruits for the service of mankind'.¹⁷ This was a symbolic victory, for the Nyabingi movement represented the most sustained challenge to colonial authority in Uganda, and for the missionaries the antithesis of Christianity and civilisation.¹⁸ In establishing a Christian leprosy settlement on Bwama Island, the CMS was dually triumphing by evangelising and civilising primitive Ugandan people and primitive Ugandan land. Figure 7 shows the mission's impression of the land's physical transformation.

The site for the FMSA's first leprosy settlement, at Nyenga, was chosen primarily for its geographical location, though the site was small, in the midst of a relatively densely populated area, and without an adequate water supply. At the time, the FMSA did not consider these concerns to be of paramount importance, as the settlement was intended to serve the Baganda and it was believed that there was a relatively small incidence of leprosy among this ethnic group.¹⁹ Far more importantly, the settlement was near the FMSA hospital

¹⁵ 'A Leper Settlement on Lake Bunyonyi', *Uganda Herald*, 28 July 1933.

¹⁶ L.E.S. Sharp, 'Plans for the Leper Work', *Ruanda Notes*, 30 (October 1929), 6.

¹⁷ Birmingham, CMS/G3/AL Beatrice Martin, 1934.

¹⁸ H.B. Hansen, 'The Colonial Control of Spirit Cults in Uganda', in Anderson, D. and D. Johnson (eds.), *Revealing Prophets: Prophecy in Eastern African History* (London, 1995), 143. For more on Nyabingi see: E. Hopkins, 'The Nyabingi Cult of Southwestern Uganda', in R. Rotberg and A. Mazrui (eds.), *Protest and Power in Black Africa* (New York, 1970), 60-132; J. Freedman, *Nyabingi: The Social History of an African Divinity* (Tervuren, 1984).

¹⁹ Bishops House, Jinja, Uganda (BH), Nyenga Leper Camp, Mother Kevin's Proposed Scheme for New Leper Colony, 1933.

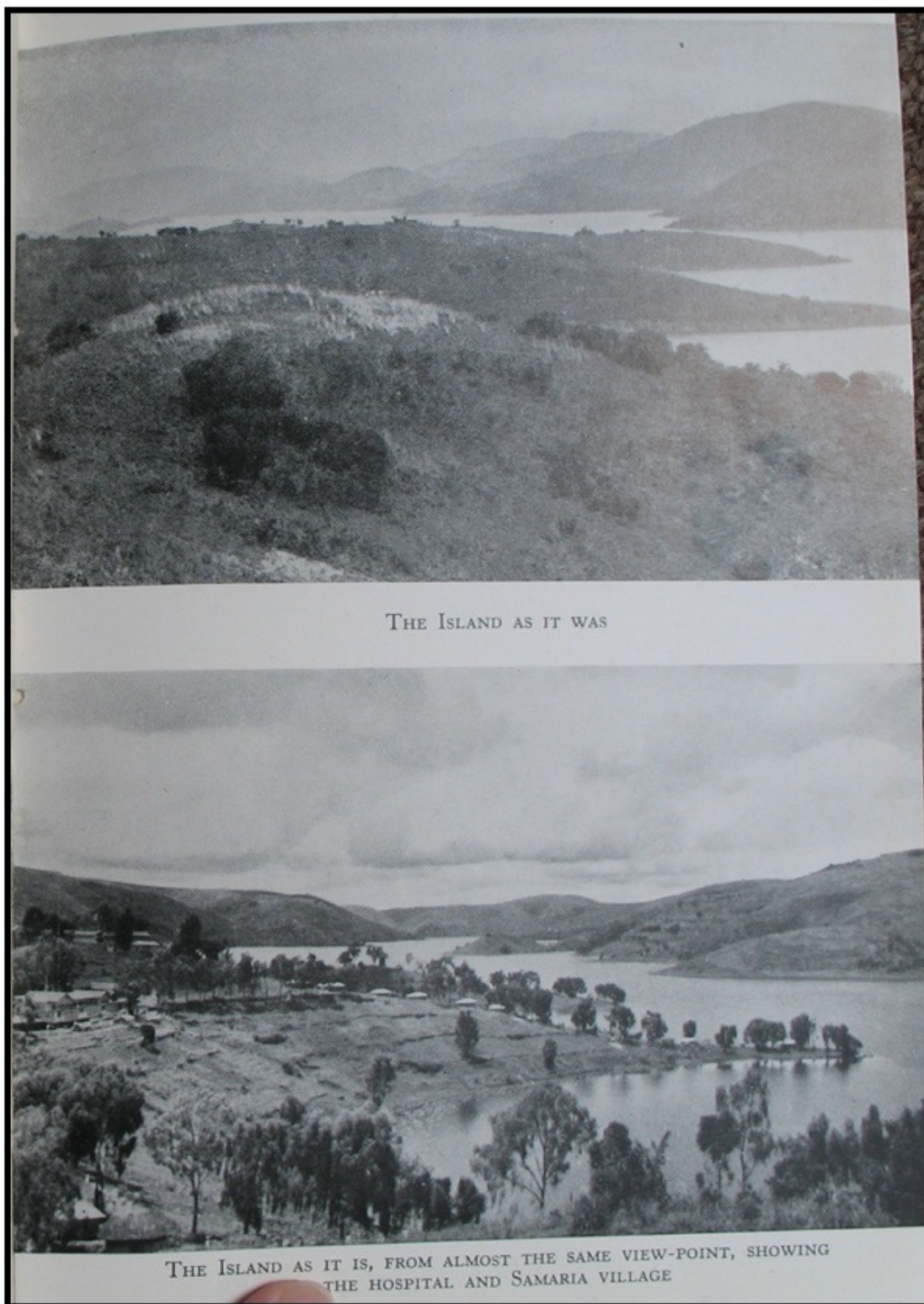


Figure 7: L.E.S. Sharp and J. Metcalf, *Island of Miracles* (Clapham Park, 1952).

and convent at Nkokonjeru and the government's hospital at Jinja, the staff of both being necessary for the maintenance of a leprosy settlement. The site was next door to a Mill Hill Mission (MHM) station, which allowed the MHM Fathers to help with the construction of the settlement and provided the FMSA Sisters an established base from which to work. Fortunately, the settlement was also 'very beautifully situated about four miles from Lake Victoria', which marked the border between Buganda and Busoga.²⁰ It is likely that Buganda's Native Administration would have objected to a leprosy settlement located much closer to the district's centre; of all Uganda's ethnic groups, the Baganda held the greatest stigma towards leprosy.

Nyenga rapidly became over-congested, and consequently the FMSA searched for a new, larger site on the shores of Lake Victoria, and within reach of the hospitals at Nkokonjeru and Jinja. As Mother Kevin wrote:

All who have any knowledge of the work understand the absolute necessity of large open spaces where the air can freely circulate, and of areas for cultivation, where the leper can live a normal life, and it is quite apparent that if we are to cope in any way with the leper problem steps must be taken for the development of the work on a much larger scale altogether. A Leper Colony covering a large area of land is the only solution to this problem.²¹

Ultimately, the alternate site they were considering in Buganda was abandoned in favour of founding a leprosy settlement in Busoga. Given the constraints of water and space experienced at Nyenga, these were the primary considerations that the mission and government shared when choosing a site for Busoga's leprosy settlement. Buluba's leprosy settlement was opened on a large tract of land, on the shores of Lake Victoria, which had been cleared of its Ugandan population several decades before as a sleeping sickness control measure. Situated close by an MHM tile-making enterprise, with ready access to water, plenty of space for growth, and no nearby local population to resent the encroachment upon their land, the re-purposed land at Buluba was an ideal site for a new leprosy settlement.

²⁰ St. Francis Hospital, Nyenga, Uganda (Nyenga Hospital), Mother Kevin speech transcript, late 1930s.

²¹ BH, Nyenga Leper Camp, Mother Kevin's Proposed Scheme for New Leper Colony, 1933.

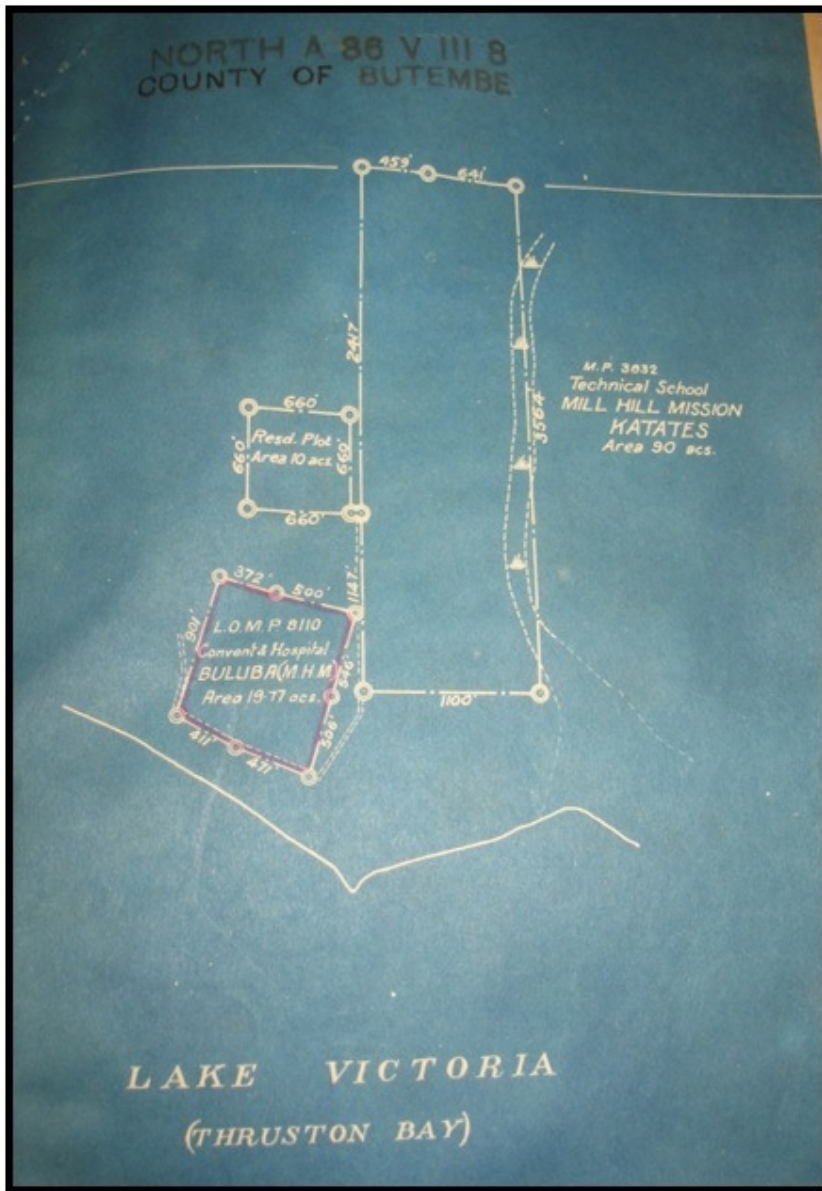


Figure 8: Land Lease, Buluba, 1937, JDA, Buluba Leper Camp.

Laying out Leprosy Settlements

After the site of each leprosy settlement had been chosen, Uganda's leprosy missionaries carefully planned the layout of the settlement, ensuring that the use of space within the settlement would support the pursuit of their ideals for civilisation and the creation of model villages. The missionaries' first consideration was the grouping of buildings in an isolated

space that would encourage leprosy patients to remain within the settlement. Ideally, this would be accomplished by placing a geographical obstacle between the settlement and neighbouring communities, as in the case of the Lake Bunyonyi island settlement. In the absence of such an obstacle, the missions used the land that they had available to act as a buffer between the settlements' buildings and neighbouring populations.²² Figure 8 shows the plots of land available to the FMSA for the Buluba leprosy settlement. At the time of the map was drawn, in 1937, most of the settlement's buildings were erected on the 19.77 acre plot outlined in red, with Lake Victoria bordering it on one side, and uncleared or farming land surrounding its other three sides. In the 1930s, houses for married couples and unmarried men were also built on the smaller 'residential plot' situated adjacent, but after the 1941 sleeping sickness outbreak, these smaller houses were relocated on the fringes of the main hospital plot, so that all of the settlement's residents would be centrally located and thus more easily supervised (see Figure 6, page 62).²³ The immediately neighbouring land was used for cultivation and surrounded by a ditch dug to protect crops from wild pigs; warded off for sleeping sickness control; or remained wilderness, acting as a buffer between the settlement and its neighbours. Kumi, Ongino, and Nyenga were arranged similarly, but without a lake or wilderness to act as a buffer the missions instead built in the centre of their allotted plot, using the surrounding land for cultivation and as a buffer (see Figures 9 and 10).

The buildings within each leprosy settlement were laid out slightly differently, depending upon the visions of the individual missionaries involved in settlement building projects over the years. As the daughter of CMS Dr. Sharp recollected, her parents took great care to ensure that the settlement was 'well laid out, with the intention of having something that was beautiful...practical and healthy for everybody'.²⁴ The leprosy settlements at Kumi

²² A. Majstorac-Kobiljski, 'Buildings of Change' (unpublished), 5.

²³ JDA, Medical Leprosy, Letter from DMO Busoga to DC Busoga, 2 August 1941.

²⁴ Interview with Joy Gowers, 12 February 2010.



Figure 9: Kumi Leper Mission Hospital, 1950s (estimate), Wiggins Senior Secondary School, Kumi, Uganda.

and Buluba were laid out in a series of rectangular courtyards, distinguished by tidy dirt roads, bordered by hedges or flowerbeds. At Kumi, these courtyards separated the centrally located boys' and girls' dormitories from the settlement's more public buildings. On opposite sides of the residential courtyards were the dining hall, and the chapel and medical buildings. Beyond these large public buildings, obscured from sight by neat rows of trees,

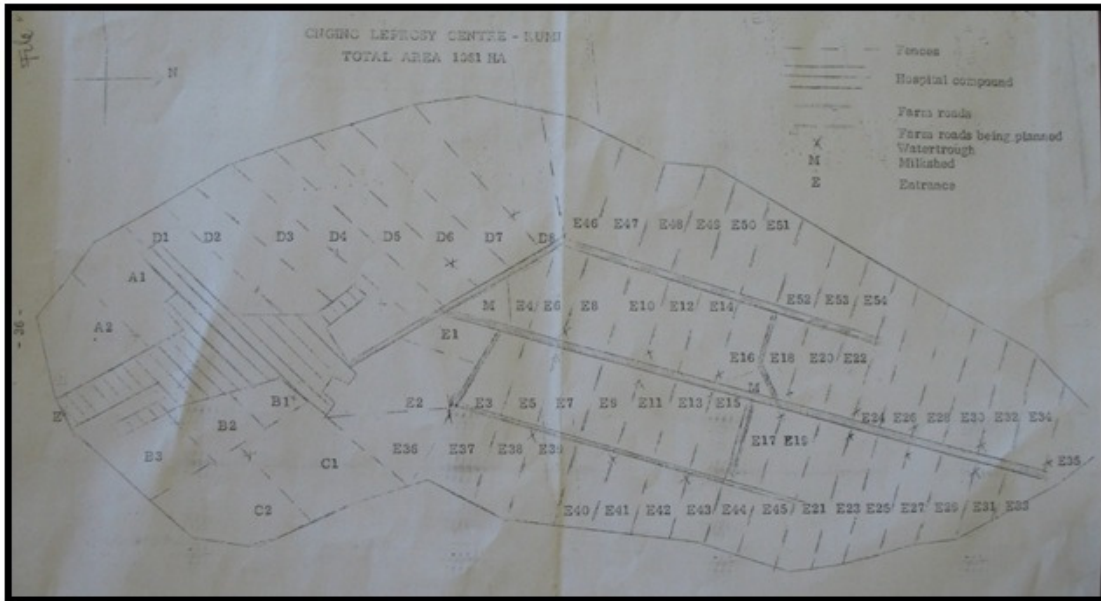


Figure 10: Ongino Hospital, Hospital Compound in shaded area, remainder for cultivation, Kumi Hospital, Uganda.

were smaller buildings such as the kitchen, laundry, and latrines (see Figure 9). At Buluba, the central courtyards housed the boys’ dormitories and school; the fenced-off girls’ dormitories and school and the men’s quarters; the women’s dormitories; the infectious men’s quarters; the medical buildings; and the chapel. Several courtyards on the northern edge of the settlement enclosed married couples’ houses and cultivation plots (see Figure 6, page 62). Nyenga and Ongino were similarly segmented by paths, but instead of being laid out in rectangles, their shaping was more irregular, and at Ongino the residential areas were a slightly greater distance from the centralised public buildings. At Nyenga:

The Sisters’ Quarters are adjacent to but outside the Settlement. The Settlement has a general rectangular layout on gently sloping ground which has been terraced and grassed by the labour of the patients. The buildings are well-spaced, with central administrative building Church and School at one end of the rectangle, laundry and kitchen at the opposite end, dormitories and living quarters on the long sides, and off the main rectangle a separate area of huts for the married couples.²⁵

Insofar as possible, all of these settlements used paths, shrubbery, trees, and buildings to separate different groups of patients as they felt appropriate, whether it was boys and girls, as at Kumi, or men, infectious men, women, boys, girls, and married couples, as at Buluba.

²⁵ UGA, J6/25I, Dr. Innes Report 1.

They created a geometrised, orderly space in which people and activities were separated according to each mission settlement's vision of the best way for leprosy patients to live their lives.²⁶

The settlement on Bwama Island was laid out differently from Uganda's other leprosy settlements, both because the missionaries were building on a physically different space and because they envisioned the creation of a more diffuse community, based around several 'model villages' rather than one model village and a number of dormitories for unmarried patients. As such, the Bunyonyi settlement also most closely resembled the typical settlement pattern of its most dominant ethnic group, the Bakiga. The Bakiga typically lived in fenced family compounds, usually grouped together on the slopes of hills. A handful of families would have nearby homesteads in close proximity, and their plots of land for cultivation would be grouped together at a slightly further distance.²⁷ The difference between Bunyonyi and the distribution of land and houses among neighbouring Bakiga was that outside of the settlement, houses and cultivation plots were often freely intermingled. However, in the interest of oversight and easy access to all leprosy patients, the missionaries instead built all patient housing on Bwama Island, and relegated the cultivation area to the more distant mission plot.

Because all of Lake Bunyonyi's settlement's buildings were erected on an island, with the main cultivation area on the mainland an hour's canoe away, there was no need to group all of the buildings into a central location. The water of Lake Bunyonyi acted as a far more effective buffer than the cultivation land or wilderness that surrounded the other settlement centres, and so the settlement's buildings could be spread across the island. To separate different groupings of buildings, Bwama's CMS missionaries took advantage of the geographical features of the crater island, using hills and promontories to separate the island

²⁶ Bonneuil, 'Development as Experiment', 271; M. Adas, *Machines as the Measure of Men* (Ithaca, 1989), 259-65.

²⁷ M. Edel, *The Chiga of Western Uganda* (New York, 1957), 195.



Figure 11: Lake Bunyonyi, from the air, showing Jericho school (top left), the hospital (centre) and Bethlehem [untainted children's creche] (right), *Ruanda Notes*, 118 (1952).

into sections: 'The island itself is very hilly, so that in the physical sense at any rate, life is "full of ups and downs!"'²⁸ Infectious and non-infectious leprosy patients were located at opposite sides of the island. On two promontories of one side of the island, as you can see in Figure 5 (page 60), were the village of Bethany for non-infectious patients and the school for non-infectious and healthy children. On the next largest promontory was the village of Samaria, also for non-infectious patients, and on the island's final two promontories were the villages of Jericho and Nazareth, which contained houses and a school for infectious leprosy sufferers.²⁹ At the top of the island's three hills were perched the lady missionaries' house, the crèche for 'untainted' babies, and as of 1947, a church. In a dip between two hills, centrally located, was the hospital (see Figure 11). Within each village, small houses for leprosy patients were grouped along the roads, and similar houses for staff lined the roads

²⁸ Birmingham, CMS/G3/AL Janet Metcalf 1946.

²⁹ The names of these four villages were chosen for their symbolic biblical reference. Bethany was the village where Jesus raised Lazarus from the dead. Lazarus was the patron saint of leprosy patients in medieval Europe. Nazareth was Christ's home during his childhood. In Samaria, Christ miraculously healed ten leprosy sufferers of their disease. Jericho, where lived the most infectious leprosy patients, was the destination of Moses and the Israelites after bondage in Egypt and forty years in the desert.

between the non-infectious villages. In the case of the Bunyonyi settlement, roads connected patients' homes to public buildings, while geographical features separated infectious, non-infectious, and healthy staff and children.

One common feature in the layout of each leprosy settlement's layout was the location of the missionary's house. In each case, the lady missionaries lived in close proximity to the settlements, while the missionary men, the majority of whom only worked at the settlement part-time, lived at a greater distance. Unlike the homes of the settlements' Ugandan staff, the missionary houses were always placed at a distance from the settlement's centre, were built with a veranda, and when possible in the spot with the most beautiful view. At Lake Bunyonyi, the Ladies Home was built atop Bwama's highest hill, allowing them to quite literally oversee the entire island, along with giving them the most scenic views. At Buluba, the missionaries' convent was built at the edge of the settlement, with a veranda facing out onto Lake Victoria and a garden before it. At Kumi and Ongino, the missionaries' house was placed on an entirely separate plot of land from those used for the leprosy patients; it is just visible at the top of the map in Figure 9 (see page 122). At Nyenga, the convent was also placed at the edge of the settlement, though the space allowed for building was so small that as the hospital grew, the convent was no longer on the periphery. In all cases, the missionary ladies wanted to be close enough to oversee their leprosy patients, but far enough away to physically distinguish themselves from Ugandan patients and staff, and to give them a greater measure of privacy and status.

It was also important to the missionaries that this orderly space be beautiful and comfortable.³⁰ Paths were always lined with stones, hedges, or trees, and it was part of leprosy patients' communal work to sweep the paths daily, trim the hedges, and cut the grassy courtyards evenly. At Ongino, the missionaries further encouraged patients to create

³⁰ Majstorac-Kobiljski, 'Buildings of Change', 12.

beautiful, orderly, and civilised spaces by awarding prizes for the ‘best gardens’, and at Kumi, ‘The aspect is very pleasant, because of being set in trees planted in a formerly treeless waste and grown up to a useful height, and the planned avenues and whitewashed guide stones of same’.³¹ Visitors to the Lake Bunyonyi settlement were always ‘thrilled with the beauty around us’, for ‘the island has gardens and lawns and paths and trees which are most attractive, and from almost any part of the island can be obtained grand views of loch, mountains, and sky’.³² Buluba was accounted to be ‘beautifully situated’ with a ‘green, pleasant, and open’ aspect, and Nyenga was ‘our dream come true...From the Chapel one walks down an avenue lined with flowering trees...The whole place is laid out in neat terraces of grass. “Just like the Governor’s place, and so soft to our poor feet,” as one leper has described it’.³³

Building Leprosy Settlements

The erection of buildings was a regular and important feature in the reports and correspondence about leprosy settlements that Uganda’s missionaries sent back to their headquarters in Britain and Ireland. Building was integrally tied to the growth of each settlement, comprised a large part of the settlements’ budgets, and was a mark of the leprosy settlements’ progress, not merely in terms of patient numbers, but also in terms of the visible establishment and growth of ‘civilised’ institutions.³⁴ Building symbolically enacted the progress of civilisation, as areas of wilderness, ‘primitive’ habitation, or witchcraft were taken over by, for example:

Three square miles of happy village life, broad swept roads, bordered with white stones, pleasant little houses each in its own garden: a huge dormitory where live the helpless old folk: rows of neat beds on the spotless floor of the large dining room

³¹ Leprosy Mission, 119/4, Report on Ongino, 1940; UGA, J6/25I, Innes Report 4.

³² G. Mash, ‘Tells of Joy on the Leper Island’, *Ruanda Notes*, 68 (May 1939), 18; UGA, J6/25I, Innes Report 5.

³³ Nyenga Hospital, Mother Kevin speech transcript, late 1930s; UGA, J6/25I, Innes Report 3; ‘Round the Missions’, *Day Star in Africa*, 12 (January 1949), 12.

³⁴ Majstorac-Kobiljski, ‘Buildings of Change’, 16.

where so much care is expended on the best foot of the right kind: the neat hospital and dispensary: the huge assembly hall which is also the place for worship.³⁵

The missionaries and colonial government set great store on the materials and designs used for building projects, classifying buildings along three lines: permanent, temporary, and primitive. 'Permanent buildings, erected with burnt brick walls, corrugated iron or tile roofs, and cement floors, with a hygienic architectural design, best expressed the physical growth of civilisation.'³⁶ These 'permanent' buildings were also the most expensive, however, and so the settlements also comprised a large number of 'temporary' dwellings, which combined 'traditional' Ugandan and 'modern' colonial building techniques, along with 'primitive' dwellings of grass or mud that were erected by the leprosy patients in their own fashion. The first priority for 'permanent' building was the construction of large buildings such as missionary houses, hospitals, and dormitories, which meant that many leprosy patients, especially at Lake Bunyonyi and Ongino, were living in 'temporary' or 'primitive' accommodation, often 'in their own native huts...just as they would do in their own villages'.³⁷

While each mission ultimately envisioned their leprosy settlements as comprising entirely permanent buildings, their sources of funding and priorities for what types of buildings should be erected affected how quickly the settlements were able to transition from 'primitive' and 'temporary' to 'permanent' and 'civilised'. Almost all of the building at Kumi was permanent, because housing child patients in dormitories meant fewer buildings were needed, and because they had the support of the government and the Mission to Lepers for building grants. The other CMS settlement sites, at Ongino and Lake Bunyonyi, displayed far greater variety in building methods and materials, mostly because the CMS

³⁵ Leprosy Mission, 119/5, Gertrude Hopkins, 'Leper Work at Kumi and Ongino', August 1945.

³⁶ Majstorac-Kobiljski, 'Buildings of Change', 18.

³⁷ Leprosy Mission, 119/4, Letter from Rev. Calcraft to Anderson, Secretary, Mission to Lepers, 7 August 1935.

favoured the housing of leprosy patients in small units, within houses rather than dormitories, as more approximate to a 'normal' lifestyle.

For the first few years after the Lake Bunyonyi leprosy settlement was opened in 1931, almost all of the patient housing was in the form of 'native huts', organised in four villages.³⁸ The houses would have followed the style of the Bakiga, the settlement's dominant ethnic group. In precolonial times, Bakiga men built huts with papyrus and grass thatch, but during the colonial period it became more common to build walls with wattle and daub, and the government eventually made this mandatory in 1935.³⁹ Most of the 'native huts' at the leprosy settlement were built out of mud and wattle with papyrus and elephant grass thatching, but even into the 1940s there were a few grass huts, and even a grass school (see Figure 12). In 1934, the missionaries and government began discussing the erection of 'permanent', 'model cottages' of sundried bricks instead of mud and wattle, both because of the continued maintenance that 'these old grass huts' required, and because the Director of Medical and Sanitary Services deemed grass huts to be unhygienic.⁴⁰ When the materials were available, these 'houses are being built with burnt bricks, corrugated iron roofs, cement floors, each containing two rooms, and separate cook houses a little apart'.⁴¹ When corrugated iron was not available, due to its expense or wartime shortages, they used Bakiga methods of papyrus thatching for the roofs (see Figure 12), and when cement supplies were limited, they used burnt brick for flooring.⁴² The necessity of replacing 'temporary grass huts by permanent burnt brick cottages as soon as may be possible' was consistently reiterated throughout the 1930s and 1940s, for however many 'model cottages' patients might build, they could not afford to put them up fast enough to match the growing population of the

³⁸ E. Sharp, 'Mrs. Sharp Writes on Behalf of the Busy Single-handed Doctor', *Ruanda Notes*, 43 (October 1932), 8.

³⁹ Edel, *The Chiga of Western Uganda*, 81.

⁴⁰ KDA, Medical 1930-39, Letter from Western PC to DC Kigezi, 20 February 1934; KDA, Medical 1930-39, Letter from DC Kigezi Rogers to Sharp, 12 January 1934; KDA, Medical 1930-39, Letter from Dr. Goodchild to DC Kigezi, 19 November 1934.

⁴¹ Birmingham, CMS/G3/AL E.C. Gardner 1938.

⁴² Birmingham, CMS/G3/AL Grace Mash 1943.



Figure 12: Top: 'Nasanaeri, the Leper mentioend in Miss Forbes' letter, with his congregation', Leonard Sharp, *Ruanda Notes*, 50 (1934); Middle: 'One of the new houses on the island. A non-infectious leper's home', Leonard Sharp, *Ruanda Notes*, 91 (1946); Bottom: 'Some of the new houses on the leper island mentioned in Dr. Symonds' Letter', *Ruanda Notes*, 67 (1939).

settlements, and into the 1950s there were still patients living in ‘little round huts’.⁴³ It was important, nevertheless, to house as many patients as possible in the ‘model cottages’, which were a more permanent expression of civilisation, and more hygienic. To this end, Bunyonyi’s missionaries started brick-building and carpentry industries on the island, so that they could provide much of their own expertise and materials for these buildings projects. After all, one of the aspects of the leprosy patient’s ‘new life’ was ‘a healthy house in which to live’.⁴⁴

When the CMS moved their primarily adult leprosy settlement from Kapiri to Ongino in 1934, they first built a dispensary, sick ward, and staff houses in permanent materials in the settlement centre, with the leprosy patients ‘dotted about the area living in their own native huts (though we are getting on as fast as we can with a more hygienic type of house)’. The predominant ethnic group at the leprosy settlement during this time, the Iteso, built their houses of mud and wattle, with grass-thatched roofs (see Figure 13). Due to lack of funds, many of the new houses built in the mid-1930s were of cob. Although this meant using mud for building, it had the benefit of being a form of building used in Europe’s past as well, and the houses were designed with two to three rooms, in a rectangular fashion similar to the ‘model cottages’ at Lake Bunyonyi, which meant they were at least hygienic in design. The greater hygienic concern of Ongino’s missionaries was the roofing of each house: they focused their resources on using corrugated iron for the roofs instead of importing building materials for the walls, because they believed that grass roofs harboured rats, plague, and snakes.⁴⁵ In 1937, the missionaries began replacing these ‘mud’ buildings with ‘better houses of two types as quickly as possible. The cheaper kind has cement floors and iron roofs but the walls are of mud. There are two adequately large rooms. There is also a kitchen, food

⁴³ RCA, Bunyonyi Annual Report 1946; Birmingham, CMS/G3/AL Grace Mash 1949.

⁴⁴ Barley, ‘Behold, I Make All Things New’, 5.

⁴⁵ M. Laing, ‘Children’s Leper Home’, *Mission Hospital*, 40.464 (September 1936), 247.



Figure 13: Top: Iteso Hut, Boma Museum, Nairobi, Kenya; Bottom: House built at Ongino in 1937 (Pictures taken in 2010)

store and latrine'.⁴⁶ The more expensive houses had walls built of concrete blocks, moulded by the leprosy patients.⁴⁷ Descriptions of 'pleasant little houses each in its own garden', some even with flowers, were usually tied to descriptions of leprosy patients who were 'learning to conquer their affliction' and learning hygiene and sanitation.⁴⁸ The move from a 'native hut' into a more civilised abode, of 'permanent' materials, with a flourishing garden, was not just a physical change: it also signified part of the patient's transformation from 'primitive' to 'civilised' in health and spirit.⁴⁹ This change was facilitated in 1950 when brick manufacturing was begun at the settlement for the first time. Yet, as at Lake Bunyonyi, building could not keep up with increases in patient numbers, and even in the late 1940s, more traditional native houses were being built for patient accommodation, though the missionaries gave them a more 'civilised' label: 'rondavels built in murrum block with thatched rooves'.⁵⁰

At Nyenga, the FMSA missionaries started small, building one central building of brick, and then assisting patients in erecting their own homes. 'At first the lepers were housed in simple native huts of mud with a grass roof; but little by little, as we were able to beg alms, we have been able to put up better buildings, making the huts larger' (see Figure 14).⁵¹ Throughout the 1930s, most of the permanent buildings that the missionaries erected at Nyenga were large ones, intended as wards or dormitories. As most patients lived in dormitories, there was no need for brick houses, except in those instances when leprosy patients got married, in which case a special brick house would be made for them. One or two 'permanent' brick huts, with two rooms and cement floors, were built every year.⁵²

⁴⁶ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁴⁷ Birmingham, CMS/ACC/21/F/8, Miss Baring-Gould's Journal, No. 4, 1938.

⁴⁸ Leprosy Mission, 119/5, Gertrude Hopkins, 'Leper Work at Kumi and Ongino', August 1945; Birmingham, CMS/G3/A10/m1A, Langley, 'Kumi and Ongino Leper Work', 1946.

⁴⁹ Leprosy Mission, 119/4, Letter from M. Laing, 9 March 1940.

⁵⁰ RCA, Kumi Annual Report, 1950.

⁵¹ St. Francis Leprosy Guild, London, England, Annual Report, 1935.

⁵² BH, Nyenga Leper Camp, Nyenga Annual Report, 1935.

When the population grew too large to fit into the settlement's dormitories, leprosy patients also erected 'round thatched huts'.⁵³

In the 1930s, Buluba followed a similar building process to Nyenga, with a focus on the erection of large, permanent buildings for medical work, accommodation, and education. Where Buluba differed from Nyenga was in the missionaries' vision of Buluba as a 'model village', in which leprosy patients could remain 'in their natural surroundings busy with farming and maintaining, as far as possible their independence', or in other words, normality.⁵⁴ Theoretically this meant that more leprosy patients would live in small houses, and Buluba's missionaries thus faced the same challenge as CMS missionaries at Ongino and Lake Bunyonyi, which was the added cost and effort of building numerous, smaller 'model houses'.⁵⁵ Unmarried men and married couples lived in houses at Buluba, and consequently the number of homes to build was great enough that the missionaries rarely built permanent homes, instead allowing patients to build their own houses, or constructing rectangular, cob houses such as the leprosy patients at Ongino built (see Figure 14). This meant that when the Eastern Provincial Medical Officer assessed Buluba in 1951, he deemed that the buildings in Buluba's centre were sufficient, but 'the housing of the leper families living their ordinary village life in the attached settlement leave very much to be desired'.⁵⁶

In the mid-1940s, Buluba's buildings came under much more extensive criticism from visiting colonial government officers. In 1943, the District Medical Officer wrote that:

The sanitary accommodation in the matter of Latrines and baths is grossly defective. The separate (Mission constructed) huts...are highly dilapidated and barely fit for human habitation...The "Settlement" houses belong to and have been built by the inmates, and consist of the usual type of grass or mud and grass hut'.⁵⁷

⁵³ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁵⁴ 'Round the Missions', *Day Star in Africa*, 13 (April 1949), 8; FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁵⁵ BH, Nyenga Leper Camp, Buluba Annual Report, 1934.

⁵⁶ JDA, Medical Leprosy, Letter from Eastern PMO to DMS, 26 August 1941.

⁵⁷ JDA, Medical Leprosy, Letter from DMO Busoga to DC Busoga, 15 July 1943.

This opinion was later repeated by a higher authority; after a 1946 visit, the Director of Medical Services was ‘not favourably impressed by the state of the buildings and the general cleanliness’.⁵⁸ On this visit, the ‘appearance of dilapidation and lack of attention’ was considered a consequence of the uncertainty that had surrounded Buluba’s future since the 1941 outbreak of sleeping sickness. Between 1943 and 1946, before the government definitively decided not to move Busoga’s leprosy settlement to another site, the FMSA was directed not to erect any permanent buildings. However, once it was decided to keep Buluba open, Uganda’s Director of Medical Services recommended that any existing ‘temporary huts’ be replaced by ‘permanent houses on the lines of those at Ongino in Teso’.⁵⁹ Thus, from this point onwards, Buluba’s missionaries began building patient houses that resembled those at Ongino and Lake Bunyonyi (see Figure 14). The missionaries reaffirmed their desire to create a model village within Buluba, though heretofore the majority of its leprosy patients lived in dormitories. In planning new building, they wrote that ‘the houses we design should be arranged in the form of a small village, which is preferable in every way for people who should reckon to be permanent inhabitants’.⁶⁰ Around this time period, in the mid-1940s, Buluba’s tile-making industry, which had supplied the roofs of many buildings across colonial Uganda, gave way to brick manufacture, which increased the ease with which leprosy patients at Buluba could build ‘civilised’ and hygienic houses for the accommodation of all patients, not just those in dormitories.

Model Society

Missionaries in all four of Uganda’s leprosy settlements expressed a desire to recreate a normal life for leprosy patients within the settlements, and in all cases but Nyenga, they further expressed a desire to create ‘model villages’ or ‘model colonies’. The ‘normal life’

⁵⁸ JDA, Medical Leprosy, Letter from Eastern PC to DC Busoga, 25 September 1946.

⁵⁹ JDA, Medical Leprosy, Letter from Eastern PC to DC Busoga, 25 September 1946.

⁶⁰ JDA, Medical Leprosy, Letter from Mother Solano to DC Busoga, 4 October 1945.



Figure 14: Top: Leprosy patients at Nyenga, Mill Hill Mission Archive, Freshfield, England, PER/1911/320; Middle: Temporary 'mud' house, Buluba (photo taken in 2010); Bottom: 'New and old styles at Buluba', *BELRA Quarterly* (October 1951), 74.

that missionaries considered so important for leprosy patients meant the pursuit of ‘normal’ activities such as cultivation, living with family or in small groups, and improving in health enough to undertake these activities. Model villages would then improve upon normality, integrating the best of Ugandan ‘tradition’ with aspects of modern, British ‘civilisation’. Creating normal and model lives involved the missionaries engineering the social, political, moral, and economic lives of leprosy patients along lines that satisfied their ideals for the patients’ future, and through them, Uganda’s future.

A Normal Life

The missions’ attempts to recreate a ‘normal’ life for the men and women who resided in leprosy settlements began with the home. This entailed not only a consideration of the design, construction, and placement of these homes, but also which patients would live together in each home. It was important that ‘the leper must be surrounded by his normal social life as a human being’.⁶¹ Uganda’s leprosy missionaries were wont to write that institutionalised life and dormitory homes were unnatural and therefore damaging to the happiness of leprosy inmates. At Lake Bunyonyi, the CMS missionaries interpreted this as family life: ‘Here on Bunyonyi the leper may live with his wife and children, sowing his seed, tending his crops, and leading a normal life, while able to obtain regular treatment for his suffering from the hospital’.⁶² Yet while life among family members was undoubtedly more ‘normal’, it increased pressure on the settlements’ space and resources, which is one explanation for absence of ‘untainted’ relatives and family units at Nyenga, just as that settlement’s very limited space goes some way to explaining the dormitory accommodations of most patients.⁶³ Buluba, at least, housed a handful of healthy family members, and placed

⁶¹ ‘Wee Donegal Priest’, *St. Joseph’s Advocate* (Ireland), 6.1 (1950), 18.

⁶² Langley, ‘Cleanse the Lepers’, 312.

⁶³ UGA, J6/25I, Innes Report 1.

married couples and unmarried men in small houses, where they could live their 'ordinary village life'.⁶⁴

The other aspect of 'normal' life that all of Uganda's leprosy missionaries agreed on was the pursuit of 'normal' activities, cultivation primary among them. The missionaries perceived cultivation as a normal activity for all Ugandans, for some ethnic groups more than others. A CMS missionary wrote of the Bakiga patients at Bunyonyi:

All the time they have the sense of freedom and a real home life. Even the very crippled ones usually beg for a little field to cultivate, and it is an amazing sight to see some leper without fingers, hanging on to a hoe with just the palms that are left!...These people just love to cultivate, and even the blind want to do their bit. We have one arrested leper girl, Eseteri, training as a nurse at Mengo hospital, and when I was in Kampala recently, she came to visit me. She was obviously very thrilled with it all, and told me wonderful tales of the wards, and the various classes. But suddenly her face fell, and she said in a little, shocked voice, "But do you know, Mukyara, They won't let me do any cultivation." It is truly a terrible responsibility to divide a Mukiga from his fields!⁶⁵

Missionaries believed that undertaking this daily activity would create a semblance of normality in the lives of leprosy patients, since they were 'looking after their little plots of land, just as they would do in their own villages'.⁶⁶

Further, missionaries and leprologists joined in the opinion that physical activity, and especially cultivation, would benefit a leprosy patient's health by improving their physical fitness and giving them confidence and independence. One eminent British leprologist, Dr. Muir, wrote on visiting Buluba that: 'Among the praiseworthy qualities should be mentioned the attempt to keep the patients in their natural surroundings busy with farming and maintaining, as far as possible their independence'.⁶⁷ Uganda's leprosy missionaries agreed; requiring leprosy patients to grow their own food and 'work for themselves' was 'a very valuable proceeding, physically, mentally and spiritually'.⁶⁸ 'These patients are taught

⁶⁴ JDA, Medical Leprosy, Letter from Eastern PMO to DMS, 26 August 1941.

⁶⁵ Birmingham, CMS/G3/AL Janet Metcalf 1946.

⁶⁶ Leprosy Mission, 119/4, Letter from Rev. Calcraft to Anderson, Secretary, Mission to Lepers, 7 August 1935.

⁶⁷ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁶⁸ FMSA, e. Nyenga, Early Days in the Leper Settlements.

independence which reacts favourably on their physique and improves their chance of recovery'.⁶⁹ Labour was cast with so much health importance that in the 1940s, 'occupational therapy' was often used synonymously with 'cultivation' in the missionaries' reports and correspondence.⁷⁰ While it could be supposed that this was a self-serving substitution, especially for the CMS leprosy settlements, where the missionaries relied on patients to grow most of their own food, the sentiment was also echoed by expert medical opinion: 'Work in the garden or field is excellent, and many of the deformities which render this impossible to the poorer patients would never have occurred if they had persisted in doing such work from the beginning'.⁷¹ Cultivation was a treatment and a prophylactic, and from this quote it is not difficult to imagine that some doctors blamed the laziness of leprosy sufferers for their deformities, though there is no evidence of this in Uganda.

Leprologists also recommended 'occupational therapy' as a means of uniting diverse groups of leprosy patients into a new, united community, and CMS missionaries in particular took up this call. When Dr. Muir visited Lake Bunyonyi in 1938, one of the measures he recommended for the settlement's future was 'developing the community life of the lepers through organized occupational therapy', and after his visit, links between community and work became increasingly common in CMS mission correspondence.⁷² In the 1940s, Uganda's leprosy settlements were becoming increasingly diverse, as leprosy patients began travelling greater distances for treatment. In discussing Ongino's new 'model farm', which required patients to work on communal farmland, rather than their own plot, one missionary wrote that: 'One of the greatest difficulties in such a polyglot community is to persuade them to work together for the common weal, and it is a credit to our patients that such little

⁶⁹ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁷⁰ Birmingham, G3/A11/g2, Bunyonyi Annual Report, 1950; FMSA, e. Nyenga, Nyenga Annual Report 1944.

⁷¹ L. Rogers and E. Muir, *Leprosy*, 3rd edn (Bristol, 1946), 247.

⁷² 'The Healing Fellowship', *Mission Hospital*, 43.500 (September 1939), 239.

difficulty was encountered'.⁷³ Such communal work was meant to draw patients together, and in its success, missionaries wrote about life at Ongino as 'a united communal effort where independence is maintained by honest labour and self respect is engendered in the pride of work well done'.⁷⁴

A Model Life: Amenities and Activities

While Uganda's leprosy missionaries hoped to recreate a 'normal' life for leprosy patients who were living in settlements, in creating model villages they hoped also to create model lives for their patients.

One component of a 'model village' was its political structure. The political organisation of Lake Bunyonyi is the best example of the missions' attempts to imprint the values and political formations of Britain onto Uganda. In 1933, the CMS missionaries organised a self-governing body, or Lukiko, for the settlement, on the suggestion of the local District Commissioner, who pointed out that 'an arcadian state of affairs is not likely, in our human circumstances, to continue indefinitely, and it is clear that a "Lukiko" will have to come sooner or later'.⁷⁵ With the 'help of the native Christians', the missionaries chose an island Chief and Lukiko representatives, two from each of the settlement's four villages.⁷⁶ The Lukiko 'administers the law, settles disputes, and keeps the peace with the aid of the one policeman, himself also a leper'.⁷⁷ Examples of the kinds of issues dealt with by the Lukiko included whether a wife had been properly paid for, small thefts, spousal abuse, and shirking cultivation work.⁷⁸ Bunyonyi was the first Ugandan leprosy settlement to institute a lukiko, by more than fifteen years. This Lukiko provided at least a veneer of democracy, and some of the missionaries saw it as a 'local parliament', or in other words, a miniature version of the

⁷³ RCA, Kumi Annual Report, 1949.

⁷⁴ Leprosy Mission, 119/5, Gertrude Hopkins, 'Leper Work at Kumi and Ongino', August 1945.

⁷⁵ KDA, Medical 1930-39, Letter from DC Kigezi to A.C.S. Smith, 26 January 1933.

⁷⁶ R. Langley, *Ruanda Notes*, 44 (April 1933), 17.

⁷⁷ Sharp, 'Lake Bunyonyi Leper Colony', *Mission Hospital*, 38.442 (November 1934), 285.

⁷⁸ Birmingham, CMS/G3/AL Grace Mash 1946.

British governing system, grafted onto Ugandan traditions, with a chief instead of a prime minister and a Lukiko instead of a parliament.⁷⁹

As far as the missionaries were concerned, the Lukiko was an imperfect method of governance, given that the Lukiko's members had great authority in the administration and maintenance of the settlement, and did not always agree with the missionaries' decisions. However, when in attendance, Dr. Sharp had final veto power over all of the Lukiko's decisions, and while it is unclear whether other missionaries were afforded the same privilege, disagreements between missionaries and the Lukiko generally seem to have been resolved in the mission's favour, or at the very least with an agreeable compromise.⁸⁰

At Kumi and Ongino, Nyenga, and Buluba, order and discipline were maintained by the missionaries in conjunction with an appointed headman or chief and Ugandan staff members, some leprosy patients themselves and others 'untainted'. In these settlements, the missionaries were organising authority in a closer approximation of what they believed was Ugandan custom, and simultaneously giving themselves a greater measure of control over the patients' lives, by decreasing the number of patients who had a formal voice in the running of the settlement. In the late 1940s, however, Ongino and Buluba followed Lake Bunyonyi's example, organising settlement Lukikos, and over the years, increasing the Lukiko's responsibilities. At Ongino, Lukiko members were chosen as representatives of their ethnic group, which suggests that part of the need for a settlement Lukiko arose through the increasing diversification of the patient body.⁸¹ At Buluba, the Lukiko was composed of six leprosy patients, supposedly 'based on the African Village pattern, by which patients were encouraged to manage their internal affairs'.⁸² The Lukiko members were labelled the 'real

⁷⁹ Sharp, 'Lake Bunyonyi Leper Colony', 285.

⁸⁰ Birmingham, CMS/G3/AL Rosa Langley 1936.

⁸¹ RCA, Kumi Annual Report, 1950.

⁸² RCA, Buluba Annual Report, 1949; St. Francis Hospital, Buluba, Uganda (Buluba Hospital), Buluba: 50 Years (1984), 6.

village elders', though they were younger than most Basoga village elders would have been, and 'Members of Parliament'.⁸³

Another component of life in a model village comprised the schedule that patients were expected to keep. The men and women of each leprosy settlement were expected to live their days and weeks according to a timetable that the missionaries created. For example, a leprosy patient's daily schedule at Lake Bunyonyi in 1931 commenced with attendance at the hospital between 6:30 and 7:30, for medical treatment and the dressing of wounds. From 7:30 to 8:30 a.m. patients could attend reading classes, and from 8:30 to 9 a.m. was family prayers. From 9 a.m. to 2 p.m., patients were encouraged to cultivate, and from 2 to 3 p.m. was another reading class. Tuesdays and Saturdays were injection days, Wednesday was 'ulcer day' and Friday was washing day, both for patients and their clothes.⁸⁴ As the settlement grew, additional scheduled activities were added, such as weekly sewing meetings and afternoon baptism and confirmation classes.⁸⁵ Even a parent's ability to see their child was scheduled; on the third Sunday of every month, after the afternoon Church service, there was a 'children's parade' during which children were brought down from the 'untainted' crèche to visit with their infectious parents.⁸⁶

There is no remaining record of a similarly strict timetable for adults at Ongino, but all patients in need of medical care attended at the dispensary for injections at 9 a.m., and afterwards a prayer service was held. Baptism and confirmation classes were taught three afternoons a week, in addition to classes in such subjects as reading, writing, first aid, handwork, building, and singing. For recreation, there was a club room available where people could gather for games and entertainment, a reading room stocked with materials in English and various Ugandan languages, Rangers for men and Rovers for women (the adult

⁸³ 'Commemorating 25 Years of St. Francis Leper Village', *Day Star in Africa*, 16 (1959), 7.

⁸⁴ R. Langley, 'Letter', *Ruanda Notes*, 38 (October 1931), 14.

⁸⁵ Birmingham, CMS/G3/AL E. Gardner 1938.

⁸⁶ E. Gardner, 'News of the Leper Island', *Ruanda Notes*, 64 (April 1938), 17.

versions of Boy Scouts and Girl Guides), Mothers Union, a football ground, and regular football matches between the men at Ongino and youths at Kumi. On Tuesday mornings, patients volunteered for community work. Patients were also responsible for cultivating their own gardens, and the settlement had oxen and ploughs available so that patients could improve upon their standard of cultivation.⁸⁷ In 1938, of the 350 patients who had been resident for longer than six months, 86 percent were self-supporting in their food supply.⁸⁸ Patients or former patients also undertook most of the other work at the settlement, for example building, teaching, medical dressing, and tailoring.⁸⁹ The Lake Bunyonyi settlement was similarly self-supporting, with patients providing almost all of the settlement's labour, staffing, and food.⁹⁰ Self-support was an important requirement for CMS model villages, not just because their financial resources were limited, but also because a model village ought to be sustainable, and model African patients industrious. As one CMS missionary wrote, of leprosy patients at Lake Bunyonyi: 'Many of them are self-supporting. This is wonderful to anyone who knows the character of the native, anyway in this part of the world, to do as little as he can, and less than that if possible'.⁹¹

Days at the FMSA Nyenga settlement were divided into community work, personal work, and recreation. Much of the cultivation was communal, with able-bodied patients spending about three hours a day, morning and evening, in the settlement's gardens and receiving a small wage for their labour, which they used to buy their food. More debilitated patients, who would not have been able to support themselves through cultivation, did the settlement's washing, cleaning, and sweeping. Sewing was taught daily, and most patients spent their free time undertaking handwork, making rope, mats, brushes, and baskets. Those

⁸⁷ Laing, 'Children's Leper Home', 247-8; Birmingham, CMS/G3/A10/m1A, M. Laing, 'Kumi and Ongino Leper Work', 1946; Birmingham, CMS/G3/AL Adelaide Kent 1938; Leprosy Mission, 119/4, Report on Ongino, 1940; RCA, Kumi Annual Report, 1947.

⁸⁸ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

⁸⁹ Laing, 'Children's Leper Home', 247.

⁹⁰ Gardner, 'News of the Leper Island', 17.

⁹¹ Birmingham, CMS/G3/AL Rosa Langley 1932.

patients who were trained to help with the medical work and buildings were paid monthly wages. Games and sport were organised in the evening and on rainy days, and the settlement had volleyball, darts, a football team and Dramatic Society.⁹²

At Buluba, each patient's day began at 5 a.m., presumably with a meal and a prayer service, and community work was undertaken between 7.30 a.m. and 10.30 a.m. The community work to which leprosy patients were assigned depended upon the missionaries judgment of their ability, and included such tasks as cooking, mending, washing, bush clearing, and gardening.⁹³ Those with special 'mental and physical capacity' were trained to undertake further jobs for the community, for example as carpenters, shoemakers, tailors, brick-makers, clerks, dressers, dispensers, or laboratory assistants.⁹⁴ Any work of this nature undertaken outside of the morning 'communal work' hours was paid on an hourly wage. Each patient was also given their own plot of land, 'to encourage private enterprise', or in other words, to grow their own food, and able-bodied patients usually undertook cultivation work in the afternoons. Those who were too debilitated to perform manual labour did handwork and sewing in the afternoons, and were paid for their work by the missionaries.⁹⁵ For recreation, Buluba hosted 'communal activities such as choral singing, dancing, games, sports and occupational therapy, according to each one's taste and ability'.⁹⁶ The settlement also had a library, a band, a football team, amateur dramatics, and volleyball.⁹⁷

Patients at both of these Catholic leprosy settlements were meant to be self-supporting: occupational therapy was beneficial to the health of a leprosy sufferer, and as Mother Kevin, founder of both settlements wrote, for a leprosy patient to be self-supporting

⁹² FMSA, e. Nyenga, Nyenga Annual Report 1940; FMSA, e. Nyenga, Nyenga Annual Report 1944; 'Our Least Brethren, 19; FMSA, e. Nyenga, Nyenga Annual Report 1939.

⁹³ 'Round the Missions', *Day Star in Africa*, 17 (April 1950), 8.

⁹⁴ Buluba Hospital, Buluba: 50 Years, 8.

⁹⁵ RCA, Buluba Annual Report 1946.

⁹⁶ Buluba Hospital, Buluba: 50 Years, 6.

⁹⁷ 'Commemorating 25 Years of St. Francis Leper Village', 22.

and contented was for them to ‘live their lives in the best possible way’.⁹⁸ Ultimately, however, the FMSA settlements spent far more money on patient upkeep and food than the CMS missionaries did.⁹⁹ Yet it was still important, for the pursuit of health and a model life, that patients live with all the amenities of ‘civilisation’, and that they their lives were ‘full and happy’.¹⁰⁰

A Model Life: Christianity and Morality

Uganda’s leprosy missionaries envisaged Christianity as the key attribute of civilisation around which model villages and model lives could be built. In order to encourage evangelisation, the missionaries made Christianity a regular part of leprosy patients’ daily lives. Scripture was taught in the children’s schools, adult reading classes were conflated with Baptism, Confirmation, and Gospel classes, and most of the reading material available for patients was religious in nature.¹⁰¹ There were daily or twice daily prayer services at each settlement, and these services were compulsory at Buluba, and at Lake Bunyonyi for patients who were weak enough to be staying in the hospital wards, which had daily prayer services.¹⁰² Missionaries also encouraged patients to form their own prayer groups, and at Lake Bunyonyi, for example, there were additional meetings of the Young Men’s Bible Class, Girl Crusaders, and twice weekly fellowship meetings. Most of the settlements did not have a chapel in their earliest years, instead holding services outdoors or in the school building, but once the churches were built, missionaries reported an increase in reverence and service attendance.¹⁰³ The demarcation and decoration of religious spaces was

⁹⁸ Mother Kevin, ‘Worldwide Appeal for the Lepers’, *The Universe* (19 January 1934).

⁹⁹ RCA, Buluba Annual Report 1947; RCA, Nyenga Annual Report 1947; RCA, Bunyonyi Annual Report; RCA, Kumi Annual Report 1947.

¹⁰⁰ ‘Our Least Brethren’, 20.

¹⁰¹ Birmingham, CMS/G3/AL Grace Mash 1947.

¹⁰² FMSA, e. Nyenga, Early Days in the Leper Settlements; Birmingham, CMS/G3/AL Grace Mash 1945.

¹⁰³ Birmingham, CMS/G3/AL Grace Mash 1947.

reported by Catholic missionaries as a particularly effective asset for evangelisation.¹⁰⁴ At Nyenga, ‘the lovely chapel...is the pride and joy of the lepers’ lives’.¹⁰⁵

The overwhelming majority of Ugandans entering the settlement were ‘heathens’, ‘with nothing of this worlds [sic] good and knowing nothing of the Love of the Saviour’, and the missionaries perceived this as ‘wonderful opportunities’ for evangelisation, as if Christianity could be built upon the *tabula rasa* of a ‘heathen’ Ugandan’s mind and character.¹⁰⁶ Missionaries expected Christianity to be the cornerstone of the settlement’s new communities, and the driving force that would impel leprosy patients to alter their values and character to embrace the tenets of service and civilisation:

There is a growing sense of unity amongst the Adults on the Ongino Colony, and the worshipping and working together has been encouraging. In many of the Patients, one sees a thoughtfulness for others. We see this, as we work amongst the Patients, by the many small incidents which occur of helping one another in times of need.¹⁰⁷

The leprosy missionaries wrote frequently about the ‘increasing evidence that Christian sympathy and Friendship has a great effect upon the general out-look of these Patients’.¹⁰⁸

The link between Ugandans and Christianity at the leprosy settlements was especially strong in narratives about Ugandan staff. These narratives expressed either the ‘truly Christian way’ in which these staffers undertook their duties, or their willingness to devote themselves to work in such an undesirable place as a leprosy settlement because of their Christian faith.¹⁰⁹

Missionaries hoped that Christianity would mould Ugandans so that they would more closely resemble the British in character, and to that end they tried to build Christian communities within the settlements that resembled Britain’s Christian communities. At the Lake Bunyonyi settlement, leprosy patients sat in church on wooden pews imported from England,

¹⁰⁴ F.J.M., ‘Wee Donegal Priest Known to Millions’, *St. Joseph’s Advocate (Ireland)*, 6.1 (1950), 18.

¹⁰⁵ ‘Round the Missions’, *Day Star in Africa*, 12 (January 1949), 12.

¹⁰⁶ Birmingham, CMS/G3/AL Grace Mash 1950.

¹⁰⁷ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1944.

¹⁰⁸ Leprosy Mission, 119/4, Report on Ongino, 1940.

¹⁰⁹ Mash, ‘Tells of Joy on the Leper Island’, 18; Birmingham, CMS/ACC/21/F/8, Miss Baring-Gould’s Journal, No. 4, 1938.

donated to the weekly church collections, and operated as a 'missionary church' of their own, sending out 'leper evangelists' to surrounding communities.¹¹⁰ They were 'great givers', in spite of their small means, and infused with a Christian spirit that at times, British congregations could not rival.¹¹¹

A strong Christian community within a leprosy settlement would also ideally ensure that the settlement's population was self-policing on issues of morality. Immorality, which was predominantly defined as sex outside of marriage, was occasionally recorded as one of the greatest problems facing the leprosy missionaries.¹¹² The first step in avoiding this problem was separating men and women, unless they were married. At Buluba, men and women lived in separate compounds, with the girl's compound placed in between, so that travel between the two compounds would be noticed. Adults and children lived in dormitories separated by gender and constructed space at Nyenga and Kumi. At Ongino, unmarried men and women lived in groups of five to six, with the men's and women's houses at opposite sides of the settlement's main compound. At Lake Bunyonyi, there were two villages each for infectious and non-infectious leprosy patients; married couples were intermingled with men's houses in one of these villages, and with women's houses in the other.¹¹³ At Lake Bunyonyi, the Bunyonyi missionaries formed a Church Council, which became responsible for judging issues that were moral rather than legal.¹¹⁴ At Ongino, missionaries felt that the settlement's discipline was so positively influenced by Christianity, it was neither desirable nor necessary to appoint a policeman, as was done at the other three settlements.¹¹⁵ Incidentally, instances such as theft were not dealt with internally, but

¹¹⁰ Birmingham, CMS/G3/AL Grace Mash 1947.

¹¹¹ Birmingham, CMS/G3/AL Esther Sharp 1946; R. Langley, 'News of the Lepers', *Ruanda Notes*, 41 (July 1932), 16-7.

¹¹² Birmingham, CMS/G3/AL Rosa Langley 1935.

¹¹³ Birmingham, CMS/G3/AL Grace Mash 1945.

¹¹⁴ 'Lake Bunyonyi Leprosy Settlement', *Ruanda Notes*, 111 (May 1950), 6.

¹¹⁵ Leprosy Mission, 119/4, Report on Ongino, 1940.

referred to the local government.¹¹⁶ Missionaries firmly believed that Christianity could persuade Ugandans to act with discipline and morality that was so necessary to the success of a model village.

A Model Life: Celebrations

Integrating Christianity with holiday celebrations was another way to promote Christianity and civilisation, and to make life in a leprosy settlement more attractive. Christmas was enthusiastically celebrated at all of Uganda's leprosy settlements, accompanied by religious services, games, dramatics, gifts for each patient, and a special feast.¹¹⁷ These Christmas celebrations were designed to bring a piece of Britain to Uganda, sometimes quite literally, as in the case of the decorations hung in Lake Bunyonyi's hospital for Christmas:

But the lepers were delighted most of all with the animals painted and cut out of cardboard that we looped on wire from the ceiling across the wards. There were monkeys and elephants and all kinds of animals they knew, and they were simply thrilled. They were given to Miss Langley by a Sister who had them in her ward in England the previous Christmas.¹¹⁸

The missionaries of Lake Bunyonyi wrote most extensively about Christmas celebrations, and frequently mentioned the joy, happiness and 'Christmassy spirit' that pervaded the colony over the holidays, just as in Britain.¹¹⁹ As one lady missionary described:

There was a real feeling of Christmas here. It began on Christmas Eve; late in the evening drums were beaten loud and long, and very early on Christmas morning, before it was light we were awakened by "Christmas awake, salute the happy morn" being sung just outside our bedroom windows, by the girl teachers and hospital girls. It was quite an unexpected surprise and they really sang beautifully.¹²⁰

¹¹⁶ Interview with Lawrence, 6 July 2010 (Kumi).

¹¹⁷ St. Francis Leprosy Guild, London, Annual Report, 1935; Birmingham, CMS/G3/A10/m1A, Letter from Secretary of CMS Medical Committee to Laing, 21 July 1943, RCA, Buluba Annual Report, 1946.

¹¹⁸ Bryson, 'Christmas on Lake Bunyonyi', *Ruanda Notes*, 56 (April 1936), 22-3.

¹¹⁹ G. Mash, 'Miss Mash, who has now arrived in England, sent us this letter, en route', *Ruanda Notes*, 88 (April 1945), 10.

¹²⁰ Forbes, 'Christmas Among the Leper Children', *Ruanda Notes*, 48 (April 1934),

The Christmas service was always crowded, with leprosy patients and Christians from nearby congregations around the lake. The Word and Gospel were preached, English and Rukiga Christmas hymns were intermingled, and in some years lantern slides of biblical scenes were shown, and apparently preferred to slides made from Ugandan villages.¹²¹ In the English tradition of Christmas feasting, in the afternoon was a great feast, followed by games, such as tug-of-war and three-legged races, which spilled over onto Boxing Day, when the children also put on a concert.¹²² The missionaries' goal was to make Christmas a time of celebration and spirituality, much as it would be in England, and in the words of one of the settlement's lady missionaries: 'It was my first Christmas in surroundings very different from those at home, but I proved it the same in the fact that it was Christ's birthday here as much as any other place'.¹²³

Christmas festivities were also an opportunity to connect Ugandan leprosy patients to donors across the British Empire. The Ruanda Mission CMS missionaries of Lake Bunyonyi relied upon donations sent from Britain and its Empire in order to provide gifts for hundreds of leprosy patients annually, including such items as soap, clothing, toys. On one occasion, children from a CMS school in India sent enamel mugs for each leprosy patient.¹²⁴ In turn, the lady missionaries spent weeks every year writing personalised thank you letters to each donor, describing how their gifts had been received and used.¹²⁵ The missionaries also relied on donors in Britain and Uganda for the funds to provide special treats for the Christmas feasts. On one occasion, a former CMS missionary from Lake Bunyonyi sent 100 pounds of salt for the feast, and the local governments of Teso and Busoga provided cattle to be

¹²¹ G. Mash, 'Christmas and Visitors', *Ruanda Notes*, 107 (February 1950), 7; Langley, 17.

¹²² N. Armstrong, *Christmas in Nineteenth-century England* (Manchester, 2010), 100-1.

¹²³ Bryson, 'Christmas', 23.

¹²⁴ R. Langley, 'Rejoicing and Tragedy on the Leper Island', *Ruanda Notes*, 40 (April 1932), 16.

¹²⁵ R. Langley, 'Letter', *Ruanda Notes*, 59 (January 1937), 23.

slaughtered for annual Christmas feasts at Kumi and Ongino, Buluba, and Nyenga.¹²⁶ Following in the English tradition of Lord Mayors' wives providing special Christmas charity, in the 1940s the Ugandan Governor's wife, Lady Hall, arranged a 'Leper Fund' that was specially intended to supplement other donations in order to ensure that all patients in Uganda's leprosy settlements received a gift and were able to partake in a feast.¹²⁷ Christmas was a special time for giving and receiving charity in Britain and its colonies, and for missionaries and British donors, Christmas celebrations provided an opportunity to become involved in a part of the civilising mission, encouraging Christianity and British festive customs.¹²⁸

Christmas also furnished missionaries with an opportunity to link religion to the food, entertainment, and gifts that leprosy patients so enjoyed. A Lake Bunyonyi missionary reported that 'Someone said that they really felt it was worth while being a leper about Christmas time because they get such wonderful gifts and also a feast that they do not get anywhere else but they could have none of these things unless their many friends in England and Africa did so much for them'.¹²⁹ Christians came from around the lake to partake in the island's Christmas celebrations, and leprosy patients came to expect the gifts and feast that came with Christmas.¹³⁰ In the settlement's first two decades, there were two years in which the mission could not afford to buy cattle for slaughter. In the second instance, in 1949, Christmas had become so associated with feasting in the minds of Bwama's leprosy patients that the missionaries used this association to support their decision not to purchase Christmas cattle. 'We also felt that the Lord was showing us the He wanted the lepers not to connect Christmas so much with the meat they usually have but to have their thoughts turned more to

¹²⁶ Bryson, 'Christmas', 23; JDA, Infectious Contagious Diseases, Letter from DC Busoga to Kyabazinga, 11 December 1948; SDA, X/NAF/9, Letter from DC Teso to Laing, 19 December 1947.

¹²⁷ Armstrong, *Christmas in Nineteenth-century England*, 105; Leprosy Mission, 118/9, Letter from Mash to Mission to Lepers, 11 December 1948.

¹²⁸ Armstrong, *Christmas in Nineteenth-century England*, 99.

¹²⁹ Leprosy Mission, 118/9, Letter from Mash to Mission to Lepers, 11 December 1948.

¹³⁰ R. Langley, *Ruanda Notes*, 44 (April 1933), 17.

Him'.¹³¹ On the other hand, though the missionaries worried that the patients would react badly to the absence of cows at their 1939 feast, their lack of complaint was perceived as 'a very definite step forward in their spiritual lives'.¹³² Mission efforts to connect special material comforts to Christianity had borne fruit.

The missionaries at Lake Bunyonyi instituted another holiday, the Harvest Festival, which was meant to encourage industriousness, gratitude, and a stronger relationship with God. The Harvest Festival was begun in 1934, and was held on a Sunday after the August harvest. All of the settlement's leprosy patients were encouraged to bring food to the church as an offering of thanksgiving to God, and the food was then sold and the proceeds used to buy Bibles and Testaments for the patients' use.¹³³ After all the food had been collected, a special guest, either a visiting CMS missionary or a local Ugandan priest, would deliver a church service, and the patients would sing the 'good old harvest hymns'.¹³⁴ In asking patients to bring the fruits of their labour as 'a gift to God', the missionaries were endeavouring to encourage industriousness, praising 'many of the lepers [who] put in a tremendous lot of hard work in the fields'.¹³⁵ They were also promoting sacrifice and charity, which they directly connected to a positive relationship with God:

One cannot help being touched to the very depth to see these poor, suffering, maimed people, including the little children, coming forward with their gifts to God often at great sacrifice. Many having to be helped forward because they had not vitality to carry their own present. On the other hand great joy was experienced in my heart to know that many of them have already given to Christ the greatest gift they could give, their own hearts.¹³⁶

¹³¹ Mash, 'Christmas and Visitors', 7.

¹³² E. Longley, *Ruanda Notes*, 71 (March 1940), 12.

¹³³ Birmingham, CMS/G3/AL Grace Mash 1939.

¹³⁴ Birmingham, CMS/G3/AL Grace Mash 1948.

¹³⁵ G. Mash, 'New of the Leper Children', *Ruanda Notes*, 66 (November 1938), 13; Birmingham, CMS/G3/AL Grace Mash 1947.

¹³⁶ R. Langley, 'Last Letter Before Leaving', *Ruanda Notes*, 62 (October 1937), 23.

Almost all leprosy patients participated in this service, and the missionaries accounted it a great success, noting with satisfaction the spirit of thanksgiving and gratitude that pervaded the island on this day.

Missionaries also believed that the successful achievement of civilisation within the leprosy settlements came with certain risks. In the late 1940s, missionaries also wrote about the dangers of civilisation to 'primitive' Africans:

These powers and the problems which they bring are beginning to make their impact upon the still primitive life in Kabale and on the leper Island – the thirst for higher pay, love of clothes and self seeking which so seen in so many of our people and the temptations of which are very real to all but our most mature Christians. Civilisation at its worst is like a germ which seems in these days to penetrate all African hearts and only the grace of the Lord Jesus and the power of His indwelling Spirit can prevent young Africa from worshipping this god.¹³⁷

Integrating Ugandan 'tradition' with British modernity was not always an easy or satisfactory prospect for the missionaries, but nevertheless almost all of Uganda's leprosy missionary writings are full of optimism of the power of Christianity and civilisation to fashion model Ugandan lives.

Model Health

The final crucial component of the leprosy missionaries' civilising mission, in addition to the ordering of space, religion, social interactions, political organisation, and economic activities within Uganda's leprosy settlements, was the pursuit of health. Good health was essential to a leprosy sufferer's ability to lead a 'normal' life, and to the formation of a truly model village. Teaching hygiene and an appropriate fear of leprosy's contagion was prerequisite to obtaining this health, and to the prevention of leprosy's spread.

Hygiene, properly practiced, was considered by Uganda's leprosy missionaries as inherent to the civilisation of Ugandans. Sanitation was primarily the responsibility of the missionaries who designed the buildings and other facilities that the patients used.

¹³⁷ Birmingham, CMS/G3/AL Marguerite Barley 1947.

Overcrowding was dangerous, and buildings had to have adequate ‘cubic capacity, light and air’.¹³⁸ Personal hygiene, on the other hand, was meant to be the responsibility of leprosy patients, and consequently missionaries expected their patients to learn appropriate hygiene, though they also believed Ugandans would find it most difficult to embrace: ‘Here indeed is one of the great battlegrounds of the work, the teaching and practice of hygiene and even ordinary cleanliness...Of course this is obviously a lesson that can only be very slowly taught, for you must remember that this is...a primitive people’.¹³⁹ And:

On Fridays we have a big washing day when all clothes have to be washed ready for inspection on Saturday. I do wish you could hear some of the excuses that are made. I honestly believe a native would from choice suffer any penalty [?] than wash himself or his clothes. Again it is a case of education and great patience with them all.¹⁴⁰

It was with pride that missionaries wrote of times when leprosy patients adopted and enforced cleanliness amongst themselves. At Nyenga:

A dirty person is no longer tolerated by the rest of the community as is evident by the blank refusal of the majority to share a room or occupy the next bed in the dormitory to a person so inclined. The orderlies have often been known to refuse injections to a person who is dirty looking until he has made himself presentable.¹⁴¹

The transformation from ‘primitive’ and dirty to ‘civilised’ and clean was one that missionaries hoped and expected each leprosy patient to undergo, especially if they were to regain their health. It was even better if leprosy patients then spread the values of hygiene to relatives not under the mission’s direct care. ‘The mental out-look of many is changing, and their care of their personal appearance and cleanliness is very noticeable. This is what we have hoped and worked for and after years of teaching, they are showing a definite desire for improvement in the Living Conditions for themselves and their relatives.’¹⁴² FMSA missionaries equated a leprosy patient’s good health, in spite of any disfiguration, with their

¹³⁸ RCA, Nyenga Annual Report 1947.

¹³⁹ Langley, ‘Cleanse the Lepers’, 313.

¹⁴⁰ Birmingham, CMS/G3/AL Rosa Langley 1931.

¹⁴¹ RCA, Nyenga Annual Report 1946.

¹⁴² RCA, Kumi Annual Report, 1947.

ability to lead a 'normal' life. 'Cleanliness and good food and other treatment soon relieve the sufferer of his intense pain. Often in three months a wonderful transformation is apparent, gradually he becomes able to live a normal life'.¹⁴³ Leprosy patients were 'learning cleanliness as well as godliness; under ideal conditions they are receiving every possible assistance in the fight for health'.¹⁴⁴

In addition to good food, the other service that missionaries believed they had to offer in the fight for a leprosy patient's health was biomedicine, and from the 1920s until the late 1940s, injections of hydnocarpus or chaulmoogra oil in particular. At Lake Bunyonyi, 'Injections have been given regularly and the teachers have done all they could to see that the children have kept themselves clean. I am sure these two things have helped to give such good results at the annual survey'.¹⁴⁵ Missionaries also considered that an appreciation of the value of biomedicine was an important part of the civilising process. Persuading patients to come weekly or bi-weekly for painful intra-muscular or intra-dermal injections was very difficult for the missionaries and staff at each leprosy settlement. Children could be more easily compelled to endure the injections if they were regularly administered during school hours, but there was very little that the missionaries could do to keep adults from evading treatment, as compulsory medical treatment was more likely to lead to 'absconding' patients than adherence. However, when the CMS missionaries at Bunyonyi went from giving 40 injections a week to 400 injections a week in 1936, they attributed 'the effect of the spiritual awakening is bringing them for their injections'.¹⁴⁶ Altogether, missionaries believed that it was the 'civilising' process that brought leprosy patients to adherence of the biomedical and hygienic practices that they declared would make leprosy sufferers healthy.

¹⁴³ Mother Kevin, 'Worldwide Appeal for the Lepers'.

¹⁴⁴ Sharp, 'Lake Bunyonyi Leper Colony', 284.

¹⁴⁵ RCA, Lake Bunyonyi Annual Report, 1948.

¹⁴⁶ Birmingham, CMS/G3/AL Rosa Langley 1936.



Figure 15: 'Samuel. An Untainted Baby', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing, (Picture published in multiple BELRA and CMS publications).

Within leprosy settlements, Uganda's leprosy missionaries believed that above all, the measure that would prevent the spread of leprosy was the separation of healthy infants from parents with infectious leprosy.¹⁴⁷ As it was generally impossible to compel parents to part with their children, missionaries had to persuade parents by educating them about the dangers of infecting their children with leprosy. One CMS missionary wrote in 1935 that:

At the moment we have 30 babies on the Island, but the parents refuse to part with them until they are weaned. Then as aforesaid it is too late. Last month I found two wee mites under 12 months both infected and the parents merely laughed when I pointed out that they had condemned their children to worse than a living death. This may be due to the parental love of the parents, but I am assured that a great deal is due to ignorance on their part and without the help of compulsory segregation, it is impossible to do more than pray that they may learn the tragedy of infecting their own children with so cruel a disease and do our utmost as far as educating them is concerned.¹⁴⁸

¹⁴⁷ A. Kent, 'Leprosy Children's Home', *Mission Hospital*, 42.486 (July 1938), 163.

¹⁴⁸ Birmingham, CMS/G3/AL Rosa Langley 1935.

The missionaries did experience measured success in persuading infectious parents to part with their young children, especially in the Catholic settlements, where the missionaries seem to have been able to use enough persuasion, or compulsion, to separate babies from their mothers without the mother ever even touching the child.¹⁴⁹ When missionaries were successful in separating children and their infectious parents, they lauded the triumph of the civilising mission (see Figure 15).¹⁵⁰

Conclusion

For Uganda's CMS and FMSA missionaries, leprosy settlements provided a special opportunity for social engineering, with relatively stable communities of Ugandan leprosy patients who were resident for years at a time and often distant from their families and former homes. These missionaries hoped to recreate 'normal' life within the leprosy settlements, and to provide a new life and new community for leprosy patients in order to replace that which they had left behind. Better even than a 'normal' life, Uganda's leprosy missionaries endeavoured to mould model lives for the men, women, and children who would live in the settlements' model villages.

Missionaries carefully chose and organised the site of each settlement, its layout, and its buildings, so that they could maximise the visible effects of Christianity and civilisation and maintain social order. They had a vision for the political, social, and economic lives that 'civilised' Ugandans would lead, and attempted to structure the activities and facilities within the settlements to fulfil this vision of an integrated Ugandan and British community. Above all, Uganda's missionaries wished to evangelise, and they promoted Christianity within the leprosy settlements by organising activities, services, and celebrations that they felt would persuade Ugandans to embrace God and then behave in a 'civilised' and moral manner.

¹⁴⁹ Nyenga Hospital, Mother Kevin speech transcript, late 1930s.

¹⁵⁰ Leprosy Mission, 119/4, Letter from M. Laing, 9 November 1936.

Finally, they sought to teach Ugandan leprosy patients and communities about hygiene and the contagion of leprosy in order to ensure the health of leprosy patients and future generations of Ugandans.

Yet although Uganda's leprosy missionaries had a detailed and ambitious vision for the future of Ugandan leprosy patients, these men and women had ideas, priorities, and values of their own, and in reality life within the leprosy settlements was a constant negotiation between the missionaries, settlement staff, and leprosy patients. It was in the care of child leprosy patients, separated from their families or adult advocates, that missionaries felt best able to pursue their ideal for the civilisation and evangelisation of Uganda.

Chapter 4: ‘Little Britons’: Children in Uganda’s Leprosy Settlements

Children played an especially important role in leprosy mission, not only in Uganda, but across the British Empire. This chapter focuses on the child-only leprosy settlement at Kumi, opened by the Church Missionary Society in 1930, as missionaries perceived in these children an opportunity to enact their ‘civilising’ and evangelising mission in ways that were not possible with adult leprosy patients.

The Kumi Children’s Leper Home was unique among Uganda’s mission institutions because it separated children of all backgrounds from their parents, sometimes for years at a time. Of all the mission institutions in Uganda, boarding schools most closely resembled leprosy settlements in this respect, but even so leprosy settlements were exceptional. During the colonial period, most elementary education in Uganda was provided through mission village schools, which children could attend while living at home. Boarding schools taught only a small minority of Uganda’s youth; in 1930, Uganda’s Protestant and Catholic missions ran thirteen boarding middle schools, six boarding secondary schools for boys, and two colleges for girls. These boarding schools drew a select population of Ugandan youths, as entry into a middle or secondary school generally required a family to reach a certain level of economic prosperity, and were subject to the influence of these families, and the educated and elite alumni that they produced.¹ Leprosy settlements, on the other hand, brought a different portion of Uganda’s population, with different economic decisions to make, into contact with the mission. Given that leprosy patients and their families were probably less economically prosperous than the relatives of boarding school students, excepting perhaps the ten percent who attended on scholarship, it was also less likely that patients or the families could afford to travel for regular visits, which meant that most leprosy patients had less contact with their family than Ugandans involved in other mission institutions.²

¹ G. McGregor, *King’s College Budo* (Kampala, 2006), 93.

² UKNA, CO/685/14, Uganda Education Department Annual Report, 1930, 10-4.

Missionaries therefore saw in these child leprosy patients an opportunity to mould civilised and Christian ‘little Britons’ without adult interference.³ This is not to suggest that children were not social actors in their own right. There is a growing body of historiographical literature emphasising the need to recognise children’s voices and agency.⁴ In addition to addressing missionaries’ vision for the shaping of malleable young Ugandan minds, this chapter will explore the responses of children to the civilising programme that they faced, and endeavour to reconstruct the perspectives of some of the young patients who lived at Kumi.

This chapter will also make a contribution to the small but growing field of colonial childhood, drawing particular tangents with literature on juvenile reformatories and child labour, the former because juvenile reformatories were the colonial children’s institutions that most closely resembled the Kumi Children’s Leper Home in their goals, composition, and segregation, and the latter because research on child labour provides some of the only historiography on African children and their perspectives.⁵ The chapter also draws on literature analysing juvenile reformatories, orphanages, and institutions for child paupers in nineteenth-century Europe, in particular Lydia Murdoch’s *Imagined Orphans*, for these children’s institutions shared the same idea as the missionaries of Kumi: dependent children needed moral training in order to become good citizens.⁶ Poor British parents and African

³ Birmingham, CMS/G3/AL, Marjorie Atkinson 1931-32.

⁴ H. Hendrick, ‘The Child as Social Actor in Historical Sources: Problems of Identification and Interpretation’, in P. Christensen and A. James, *Research with Children: Perspectives and Practices* (London, 2000).

⁵ Colonial Reformatories: C. Campbell, ‘Juvenile Delinquency in Colonial Kenya, 1900-1939’, *Historical Journal*, 45.1 (2002), 129-51; L. Chisolm, ‘Education, Punishment and the Contradiction of Penal Reform’, *Journal of Southern African Studies*, 17.1 (1991), 23-42; L. Chisolm, ‘The Pedagogy of Porter: The Origins of the Reformatory in the Cape Colony, 1882-1910’, *Journal of African History*, 27.3 (1986), 481-95; A. Dirks, ‘For the Youth: Juvenile Delinquency, Colonial Civil Society and the Late Colonial State in the Netherlands Indies, 1872-1942’, (Ph.D., Leiden University, 2010); P. Ocobock, ‘Coming of Age in a Colony’, (Ph.D., Princeton University, 2010); S. Sen, *Colonial Childhoods: The Juvenile Periphery of India, 1850-1945* (London, 2005); Child Labour in Africa: B. Grier, *Invisible Hands* (Portsmouth, 2006); J. Lord, ‘Child Labor in the Gold Coast’, *Journal of the History of Childhood and Youth*, 4.1 (2011), 88-115.

⁶ L. Murdoch, *Imagined Orphans: Poor Families, Child Welfare, and Contested Citizenship in London* (New Brunswick, 2006).

parents were a dangerous influence upon their children, and if these children had not become delinquent yet, it was only a matter of time.⁷

Children were tremendously important to leprosy mission in Uganda, based largely upon the perceptions that children were malleable and more easily influenced than adults; children were particularly susceptible to leprosy; and children were the most innocent and vulnerable people in the world. In separating children from their parents and housing them in leprosy settlements, missionaries aimed to mould Ugandan children into 'little Britons' who would eventually return to their homes and spread the light of civilisation and Christianity; to protect children from dangerous parental influences and give them a chance at a 'normal' life; and to pursue a humanitarian endeavour for which they would receive abundant British support, in a time of stiff competition for charitable resources.

Saving Child Leprosy Patients

The eighteenth century witnessed a crucial shift in the conception of childhood in Europe. As original sin became less theologically significant, children were increasingly considered to be innocent messengers of God, whose childhoods should be a time for happiness and individual development.⁸ By the mid-nineteenth century, the concept of the child was newly cemented: the child was a dependent individual with rights and privileges who needed to be protected, and whose childhood development would affect the kind of adult that he or she became.⁹ In industrial Britain, which relied so much on child labour, the working class could not afford the luxury of conforming to the idealised middle-class standards of a carefree and protected childhood. So, middle-class philanthropists came to the rescue, recasting the children of the poor as victims who needed to be saved from their

⁷ F. Driver, 'Discipline Without Frontiers?', *Journal of Historical Sociology*, 3.3 (1990), 284.

⁸ H. Cunningham, *Children and Childhood in Western Society since 1500* (London, 1995), 41, 61-2.

⁹ Cunningham, *Children and Childhood*, 41, 136.

dangerously indigent and neglectful parents in order to become healthy British citizens.¹⁰

The construction of these poor, abandoned ‘strays’ was intimately linked to British imperialism: nineteenth-century British reformers presented poor children as ‘savages’ and ‘street Arabs’, as much in need of the saving graces of civilisation as their ‘primitive’ counterparts in the colonies. Indeed, fundraisers portrayed the reclamation of British ‘street Arabs’ as essential to the imperial endeavour, for otherwise there would be no soldiers or workers to advance the Empire’s interests.¹¹ Saving poor, ‘savage’ children was therefore a philanthropic and patriotic effort.

As the ideology of childhood as a protected, innocent, and dependent phase of life became cemented in the minds of middle-class Europeans, this ideology began to influence public action, primarily through the outlet of philanthropy.¹² Nineteenth-century Britain witnessed an outpouring of financial resources for philanthropy and a proliferation of philanthropic societies.¹³ Children were a central part of this charitable expansion, for in a world where charity was often predicated upon a judgment of whether the poor and suffering were ‘deserving’ or ‘undeserving’, the perceived innocence, vulnerability, and defencelessness of children often led to them being cast as the most needy and worthy recipients of humanitarian aid.¹⁴ As such philanthropists found it relatively easy to mobilise support for children’s causes with sentimental appeals that focused on the suffering of the innocent child, at home and abroad.¹⁵

The salvation of the African colonial child gained popularity as a philanthropic and imperial cause in the twentieth century. Concerns about child welfare began shifting from

¹⁰ H. Cunningham, *The Children of the Poor: Representations of Childhood since the Seventeenth Century* (Oxford, 1991), 133.

¹¹ Murdoch, *Imagined Orphans*, 9, 24-5.

¹² Cunningham, *Children and Childhood*, 134.

¹³ F. Prochaska, ‘Victorian England: The Age of Societies’, in D. Cannadine and J. Pellew (London, 2008), 19-20.

¹⁴ L. Suski, ‘Children, Suffering, and the Humanitarian Appeal’, in R.A. Wilson and R.D. Brown, *Humanitarianism and Suffering: The Mobilization of Empathy* (Cambridge, 2009), 210.

¹⁵ Cunningham, *Children and Childhood*, 136.

the British metropole to the colonial world, and from the 1920s the image of the sick and hungry African child, so familiar in contemporary philanthropic appeals, grew more widespread.¹⁶ In 1931, the humanitarian organisation Save the Children made its first shift away from a focus on European children, holding a conference on the problem of the African child. It was missionaries who responded most enthusiastically to the call for the salvation of the African child, who set the precedent for later humanitarian aid for African children, and who spread the earliest awareness in Britain of the problem of the African child.¹⁷ The innocent and vulnerable African child needed to be saved from its dangerously ‘primitive’ parents, and introduced to a civilised and Christian childhood.

In keeping with international sentiment and scientific research, leprosy missionaries portrayed children as especially vulnerable to leprosy. This vulnerability was twofold in nature. ‘Untainted’ children were at the greatest risk of contracting leprosy, as they were considered more susceptible to the leprosy bacterium than adults.¹⁸ ‘Tainted’ children, who had already contracted leprosy, were doubly cursed with the vulnerabilities of childhood *and* leprosy. Missionaries employed this double vulnerability in fundraising propaganda, suggesting that without the donor’s intervention, child leprosy patients would have no childhood and no future. Vulnerable children formed the core of medical mission work in Africa: almost all leprosy work and maternal and infant healthcare was undertaken by missions.¹⁹

Shortly after he began out-patient leprosy treatment in Teso, CMS Dr. Wiggins started contemplating the foundation of an in-patient, child-only settlement where he could treat children for leprosy without relying upon parents for their child’s regular medical attendance, hygiene, and diet. Dr. Wiggins complained frequently that ‘parents are apt to be slack at

¹⁶ J. Beinart, ‘Darkly through a Lens’, in R. Cooter, *In the Name of the Child* (London, 1992), 230.

¹⁷ D. Marshall, ‘Children’s Rights in Imperial Political Cultures: Missionary and Humanitarian Contributions to the Conference on the African Child of 1931’, *The International Journal of Human Rights*, 12 (2004), 273-7.

¹⁸ L. Rogers and E. Muir, *Leprosy*, 3rd edn (Bristol, 1946), 72-3.

¹⁹ M. Vaughan, *Curing Their Ills: Colonial Power and African Illness* (Stanford, 1991), 66-75.

bringing [children] up for treatment’, both because the distance to be travelled to the nearest leprosy centre was too great for some young children, and because their parents ‘have not sufficient intelligence to grasp the fact that regular attendance is essential, nor the perseverance to come up weekly for their injections’.²⁰ Even when parents did bring their children weekly for injections, this treatment was not sufficient. Wiggins believed that what these children needed was ‘a daily wash and good food’.²¹ This opinion was echoed by the most eminent leprologists, one of whom was paraphrased as asserting: ‘Although medicines were useful, the main remedy lay in healthy occupation and sound nutrition’.²²

Dr. Wiggins, and the missionaries who followed in his footsteps, placed great emphasis on the treatment of child leprosy patients in the earliest stages of the disease. Leprosy doctors and nurses generally believed that if ‘early cases’ were given biomedical treatment, appropriate care, and a nourishing diet, the progress of leprosy could be halted before the patient developed any permanently visible symptoms. In any given year, five to twenty percent of the settlement’s child patients were released as ‘symptom-free’ or ‘arrested cases’. So, when missionaries wrote that ‘the child has leprosy, but in the early stage, and so there is every possibility of really curing her’, this was at least partially true.²³ There remains no cure for leprosy that will completely eliminate the *bacillus leprae* from a patient’s body, and in the 1930s and 1940s, a symptom-free child might experience a recurrence of leprosy symptoms. Kumi’s nurses and doctors dealt with this by encouraging ‘cured’ children to meet them twice a year for an inspection, and celebrating the salvation and redemption of child leprosy sufferers: ‘The majority of those boys and girls will be discharged in a few

²⁰ Birmingham, CMS/G3/A10/m1A, Letter from Wiggins to Hooper, 31 March 1929; Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 17 October 1929.

²¹ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 8 January 1929.

²² ‘The Fight Against Leprosy’, *British Medical Journal* (24 April 1937), 864.

²³ Leprosy Mission, 119/4, Letter from M. Laing, 12 March 1934.

years symptom free, their lives redeemed from suffering and misery, and the future for most of them is full of brightness and hope'.²⁴

In 1938, at the International Leprosy Conference in Cairo, the general preference for treating leprosy in children was given the weight of medical consensus. Further than stating that the treatment of leprosy was most beneficial for children physically and spiritually, leprologists agreed that treating leprosy in children was the surest path to eradicating the disease. Those who contracted the disease young had many more years in which to develop severe and infectious leprosy that would infect others, and therefore treating children would be the best way to reduce the incidence of leprosy. The medical mission of the Kumi Children's Leper Home was officially vindicated:

Also, at a conference of medical men in Cairo recently, it was stated that the most successful treatment of leprosy was that carried out among children, and of those the early cases. These two facts therefore have led us to our chief methods of treatment: first preventative, by isolating as far as we can all infectious cases; and secondly, concentrating very much on the treatment of the children.²⁵

From this point onward, visiting leprologists wrote about Kumi with great praise, as a model settlement that others should imitate. The eminent leprologist Dr. Muir wrote that: 'In some ways it is the best leper work I have seen anywhere'.²⁶ For Muir, 'leprosy must be considered largely as a child problem'.²⁷ An institution that focused on cutting off leprosy before it had a lifetime to do its damage was an institution to be admired.

In 'working for the future' of child leprosy patients, one of the greatest concerns of the missionaries was the avoidance of permanent disfiguration, which often attended advanced stages of leprosy.²⁸ To be permanently disfigured was to have no future, and thus missionaries attempted 'to save the children before leprosy destroys them'.²⁹ Europeans, at

²⁴ Birmingham, CMS/H/H5/E2, Medical Mission Auxiliary (MMA) Year in Review, 1936-37.

²⁵ A. Kent, 'Leper Children's Home', *Mission Hospital*, 42.486 (July 1938), 162.

²⁶ 'CMS Medical Missions: VII. The Care of the Leper', *Mission Hospital*, 43.498 (July 1939), 147.

²⁷ 'The Fight Against Leprosy', 864.

²⁸ Birmingham, CMS/H/H5/E2, MMA Year in Review, 1936-37.

²⁹ 'General Report for 1950', *BELRA Quarterly* (July 1951), 43.

least, were preoccupied with the appearance of leprosy sufferers, and missionaries constantly slipped references of disfigurement into their narratives about leprosy patients. The children were ‘sadly marred’ and ‘deformed’, with ‘swollen ugly faces and rotted limbs’ and ‘no fingers or thumbs at all – just stumps’.³⁰ While the missionaries displayed more moderation in their descriptions of the gruesome symptoms of leprosy in children than in adults, they nevertheless emphasised the particular value of being able to release patients without any visible signs of leprosy’s presence. Children successfully undergoing treatment were, by contrast, ‘bonny and fit’, with ‘clean shining faces’.³¹ There were frequent lamentations that children had not come to the settlement earlier, when more could have been done to prevent them becoming ‘truly terrible to look upon’:³²

The tragedy is that so few are sent here in the earliest stages of the disease, and some not until they have developed a permanent deformity of the hands and feet. I admitted a little girl the other day who had lost the sight of one eye—if her parents had sent her in a few years ago this could have been saved.³³

Treating children in the early stages of leprosy was meant to save them from both the lifelong effects of disability, and from the stigma that the British (wrongly) assumed they would face for appearing different.

Although leprosy was the premise of the foundation of the Kumi Children’s Home, the missionaries who worked there had far more in mind than the salvation of children from leprosy itself: they also wished to save children from the dangerous influence of their ‘primitive’ families. It was not only that parents could not be relied upon to bring their children for regular medical treatment, but also that ‘a very great deal of the illness which we

³⁰ Leprosy Mission, 119/4, Letter from A. Downes-Shaw to Anderson, Secretary, Mission to Lepers, 8 June 1934; M. Laing, ‘Children’s Leper Home’, *Mission Hospital*, 40.464 (September 1936), 245; Leprosy Mission, 119/5, Gertrude Hopkins, ‘Leper work at Kumi and Ongino’, 1945; Leprosy Mission, 119/5, Letter from A. Kent, 1 December 1945.

³¹ Leprosy Mission, 119/4, Letter from M. Laing, April 1935; Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children’s Home, 1935.

³² M. Lang, ‘Notes from the Children’s Leper School’, *Mission Hospital*, 37.420 (January 1933), 8.

³³ *BELRA Quarterly* (April 1950), 30.

have to treat is caused by the evil living of the people'.³⁴ Iteso parents, in particular, were considered 'ignorant and uncivilized', and 'more backward than some of the others' in the area, and Kumi's CMS missionaries perceived these parents as a danger to their children, particularly where leprosy was concerned.³⁵ Apart from many diatribes about the ignorance of parents who infected their young children with the disease, the missionaries wrote specifically of the damage that parents did to children when they went home for their annual leave:

Some of those who have come back, generally after 2 or 3 months instead of one, are very much the worse for their 'leave', as they returned dirty, dull looking and covered with sores, very different to the bright, clean little creatures who went out. We cannot refuse this leave, but it is a great pity that we cannot.³⁶

If these children had remained with their parents, their lives would have been 'not only a slow rotting of the body from the dread disease, but also mental and perhaps spiritual decay'.³⁷ It was only by entering the leprosy settlement that these children could be saved from the degenerations of ignorance and leprosy, and turned into happy, 'bright' children.

The desire to save children from their supposedly degenerate parents, taking them in as miserable, suffering creatures and shaping them into joyful children, was shared by British humanitarians worldwide, who sought to give poor children a 'proper childhood'. As the voluntary impulse merged combined with the creation of a new ideal for a happy and carefree childhood in the nineteenth century, British philanthropists looked first to the poor children who filled the streets of industrial cities. They were frequently shocked by the difference between the ideal childhood experienced by middle- and upper-class children, and the perceived absence of childhood experienced by the children of the urban poor.³⁸ Across

³⁴ J. Wilson, 'Love in Action', *Mission Hospital*, 35.396 (January 1931), 5.

³⁵ J.E.H., 'Is it Nothing to You?', *Mission Hospital*, 33.373 (February 1929), 42; Leprosy Mission, 119/4, Letter from E.B. Bull to Anderson, Secretary, Mission to Lepers, 17 July 1934.

³⁶ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 17 November 1931.

³⁷ Birmingham, CMS/G3/AL Adelaide Kent 1938.

³⁸ Cunningham, *Children and Childhood*, 136.

Europe and the colonies, philanthropists created institutions where children could be housed, taught, and given a happy and productive childhood. They believed that a nurturing, domestic environment within these institutions would be able to regenerate the childlike innocence that had been lost through hard living and the improper care of parents.³⁹ After World War I, Britain's ideal vision of poor children changed from the anti-industrial ideal of training artisans and domestic servants to the ideal of children as future soldiers and active British citizens.⁴⁰ At Kumi, however, the nineteenth-century ideal of childhood lived on, with a focus on agricultural and handicraft training that was in keeping with a British colonial vision of the Empire as the last bastion of agricultural, pre-industrial society, which evidently Kumi's missionaries shared.⁴¹

In Uganda, the Kumi Children's Leper Home was a part of this philanthropic desire to bestow a childhood upon children. The CMS missionaries wrote frequently of the poor physical and mental state of new patients, often linking these symptoms to an absence of childhood. For example, the ladies described 'a very bad case', a boy of twelve years, as 'looking more like an old man than a boy'.⁴² Miraculous was the transformation that occurred when one of the dressers took him in hand, and 'soon he returned with face shining and clad in clean garments, ready for examination and treatment, and looking like the boy he really was. That same evening this boy was found on the football field, and looking as happy and at home as if he had been with us for years'.⁴³ Time in the settlement supposedly transformed children's aged appearance and demeanours into happiness: 'That sad, unchildlike look with which they came gives place to a cheery smile, and once more they look like children'.⁴⁴ Not only did patients look more like children after several months

³⁹ Murdoch, *Imagined Orphans*, 35.

⁴⁰ Murdoch, *Imagined Orphans*, 121, 143.

⁴¹ D. Cannadine, *Ornamentalism: How the British Saw their Empire* (London, 2001), 130-1.

⁴² Kent, 'Leper Children's Home', 162.

⁴³ Kent, 'Leper Children's Home', 162.

⁴⁴ Kent, 'Leper Children's Home', 162.

within the leprosy settlement, they began to act differently, as children should: ‘They come in ragged, dirty, some without clothing at all, some with many ulcers, [but with] clean surroundings, they are entirely different. It is good to see them learn to laugh and play as only children can. It is good to see expressions of unhappiness disappear from their faces’.⁴⁵ In letters written back to their donors in Britain, the missionaries wrote about their efforts to ensure that ‘these children [are], as children should be, full of joy and happiness’.⁴⁶ This happiness was in spite of any debilitating or painful symptoms that leprosy might cause them: ‘Hundreds of little children, all afflicted with the worst of all diseases, some terribly disfigured, with swollen ugly faces and rotted limbs, yet all as happy as children can be and ought to be’.⁴⁷ The happiness of leprosy sufferers who were being treated in a settlement was a common theme in the writings of all of Uganda’s leprosy missionaries, but in children it was especially pervasive, and tied to the idea that this happiness was the right of childhood, and the gift of the mission.

Finally, Kumi’s missionaries wished to save not only the body and minds of child leprosy sufferers, but also their souls. As Dr. Wiggins expressed, ‘I believe this Hospital will give us a great opportunity for doing good, both bodily and spiritually’.⁴⁸ First and foremost in any CMS endeavour was evangelisation, and the missionaries believed that in founding a child-only leprosy settlement, they had a special opportunity to save children and give them a better future.

Moulding Child Leprosy Patients

In the creation of a children’s in-patient leprosy settlement, the CMS perceived a unique opportunity for moulding the future of Uganda as a civilised and Christian country, for they believed that children were far more malleable than adults, and particularly so when

⁴⁵ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

⁴⁶ Lang, ‘Notes from the Children’s Leper School’, 7.

⁴⁷ Leprosy Mission, 119/5, Gertrude Hopkins, ‘Leper work at Kumi and Ongino’, 1945.

⁴⁸ Birmingham, CMS/G3/AL C.A. Wiggins 1930.

they were separated from their families. The lady missionaries were especially optimistic about the possibilities for engendering civilised habits and customs among younger children, for ‘Have we not marvellous opportunities when starting with the children at an early age?’⁴⁹ At this young age, ‘impressions are so easily formed which make a man their whole lives’.⁵⁰ The mission ladies wrote quite openly about the opportunities that these child leprosy patients provided, even if their stay was short: ‘One has a wonderful opportunity amongst the children, and even if they are only with us for one year – it can be made a year full of loving teaching which is bound to leave its mark...upon their lives in the future years’.⁵¹ The perceived immaturity of children lent credence to the assumption that missionaries had a right to intervene in the lives of child patients.⁵² The goal was to bring child leprosy patients to the settlement, teach them the graces of civilisation and Christianity, and return them to their homes, healed and uplifted, in the hopes that their newly moulded characters would endure even in the ‘primitive’ surroundings of their native homes.

A Transformation of the Body and Mind: Creating Healthy Children

The first goal of the CMS missionaries at Kumi was to civilise the leprosy settlement’s children enough to allow their health to be improved. In order to encourage the mental and physical transformations perceived necessary for a child leprosy patient to achieve health, the mission ladies taught certain customs and values of hygiene and healthy living that they perceived as alien to ‘primitive’ Ugandans. Given that much disease was caused by the ‘evil living of the people’, the mission believed that a change in lifestyle was integral to the healing of a chronic disease such as leprosy, particularly for child leprosy patients, who were perceived as especially amenable to ‘cure’.⁵³ Thus the missionaries

⁴⁹ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

⁵⁰ Birmingham, CMS/G3/AL Marjorie Atkinson 1931-32.

⁵¹ Birmingham, CMS/G3/AL Marjorie Atkinson 1930.

⁵² Marshall, ‘Children’s Rights in Imperial Cultures’, 293.

⁵³ Wilson, ‘Love in Action’, 5.

pursued the health of their child patients by choosing to ‘concentrate chiefly upon a good diet, cheerful environment, fresh air, good sanitation, [and] exercises’.⁵⁴

A ‘good diet’ was consistently emphasised as vital to a leprosy patient’s improvement, and never more frequently than in discussions of child leprosy patients. The missionaries remarked that many children arrived at the settlement ‘under-nourished’ and even ‘emaciated’, and in order to be cured of leprosy, they also had to be cured of malnutrition.⁵⁵ In keeping with growing concerns over nutritional health in colonial Africa, Miss Laing noted that, ‘one of the most important items in a cure is a really good rich food in generous proportion’.⁵⁶ Improvements in health were directly linked to improvements in diet, and frequent famine and rising food prices in the 1940s meant anxiety for the missionaries, who often struggled to find the funds to feed their child patients in the manner they deemed necessary.⁵⁷

A ‘cheerful environment’ was another essential component in the recovery of child leprosy patients, not least because it was assumed that all sufferers of leprosy would feel the weight of hopelessness in the face of a chronic, incurable disease like leprosy. The missionaries therefore endeavoured to make their child patients ‘ideally happy – land cultivation – school – games etc never leaving a moment for discontent’.⁵⁸ Improvements in health and mind were intimately linked, partially because of the perceived importance of Christianity to the healing of leprosy:

The children’s leper home—although it may sound repulsive to some—is full of joyous work. Perhaps it is because we have the realization of the presence of Christ in the home. There certainly is a real spirit of love and happiness among the children, in spite of their rather loathsome disease. A happier band of youngsters it would be difficult to find anywhere.⁵⁹

⁵⁴ Laing, ‘Children’s Leper Home’, 245.

⁵⁵ Laing, ‘Children’s Leper Home’, 246; Leprosy Mission, 119/4, Letter from M. Laing, 9 November 1936.

⁵⁶ SDA, X/NAF/9, Letter from Laing to DC Teso, 3 May 1946; J. Tappan, “‘A Healthy Child Comes from a Healthy Mother’: Mwanamugimu and Nutritional Science in Uganda, 1935-1973”, (Ph.D., Columbia University, 2011), 17-18

⁵⁷ RCA, Kumi Annual Report 1946.

⁵⁸ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

⁵⁹ Lang, ‘Notes from the Children’s Leper School’, 7.

That being allowed, the CMS missionaries did not rely upon Christianity alone to bring happiness to their young patients. They believed a ‘happy school life’, work, and a wide variety of games, including elements of both British and ‘native’ customs, was the path to the ‘ideally happy’ childhood that they wished child leprosy patients to experience.⁶⁰ This happiness was more than a restoration of childhood and a gratifying result to humanitarian endeavours: it was an important part of the treatment for the incurable, chronic curse of leprosy.

The suggestion that ‘fresh air’ would improve the condition of child leprosy patients resulted from a medical emphasis on the importance of climate and environment in determining the prevalence and decline of leprosy. Although the modern treatment of leprosy never relied strongly on change in climate, possibly because the medically recommended removal of leprosy patients to ‘a temperate, dry climate without excess of heat or cold’ was rarely a viable option in the tropics, the open air as a treatment for debilitated children had a long medical history.⁶¹ Following a growth in medical theories stressing the therapeutic value of fresh air, twentieth-century Britons began extolling the virtues of open-air schooling for children, particularly those who were considered sickly and malnourished.⁶² The Kumi Children’s Leper Home also practised open-air schooling, though perhaps more through necessity than desire (See Figure 16). Overcrowding was a constant issue at Kumi: grants for new buildings did not keep up with the steadily increasing flow of child leprosy patients who needed admission. Without an adequate number of buildings for the schooling of all the

⁶⁰ Lang, ‘Notes from the Children’s Leper School’, 7.

⁶¹ Rogers and Muir, *Leprosy*, 246-7.

⁶² L. Bryder, ‘Wonderlands of Buttercup, Clover and Daisies’, in R. Cooter *In the Name of the Child* (London, 1992), 72-95.



Figure 16: 'Healthy Children Kumi', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing.

settlement's patients, learning in the fresh air was a healthy alternative to crowding indoors, all the more so because overcrowding was considered one of the primary explanations for leprosy's spread and prevalence.⁶³

'Good sanitation', as it was termed by Nurse Laing, was part of the mission's emphasis on the importance of hygiene to healthy living. Much of her discussion of hygiene was put in terms of the contrast between a child leprosy patient's surroundings and appearance inside and outside of the settlement. Outside the settlement, the children were 'ragged, dirty, some without clothing at all, some with many ulcers', living in 'homes of grass and mud', 'unhealthy surroundings' where 'undesirable customs' were practiced.⁶⁴ Inside the settlement, the children were transformed: 'entirely different', with their 'clean

⁶³ Rogers and Muir, *Leprosy*, 51.

⁶⁴ Leprosy Mission, 119/4, Letter from M. Laing, April 1935; RCA, Kumi Annual Report, 1947.

shining faces’, they were ‘disciplined and taught to live in clean and healthy surroundings’.⁶⁵ Cleanliness was not simply a physical state; it was a way of life that the missionaries endeavoured to teach and enforce. Hygiene was one of the ‘elementary subjects’ taught in school, and the perceived success of these teachings contributed to many examples of Kumi’s success as an institution.⁶⁶ One of the missionaries wrote, of a one-year-old girl: ‘Sabiti is evidently benefitting by the hygiene taught, for her whole thought was centred on waving the flies off the bottle which had been prepared and brought to the Chapel in case baby Andreyra could not wait’.⁶⁷ Of several young women who were former patients of Kumi, now grown and married to teachers in the school, Miss Laing wrote: ‘I am also very very happy as I visit them daily and see them living in clean and healthy surroundings and living up to the teaching which they have received in this Home’.⁶⁸

‘Exercises’ and work were the final components of the lifestyle that was supposed to bring about a child’s recovery from leprosy. This activity had two purposes: to occupy the mind and body in order to avoid the ‘brooding and depression’ that were assumed to accompany leprosy, and to keep the body in good health, which would aid recovery.⁶⁹ The missionaries at Kumi believed firmly in this ‘treatment’, and as they stated: ‘Agriculture, and other outdoor work occupies half of the school timetable; these being necessary both for the treatment of patients, and for the maintenance of the Settlement’.⁷⁰ Doctors also believed that physical activity was an important preventative and curative health measure for British children. Physical education, such as gymnastics and drill, was seen as a cheap and effective means of promoting health for British schoolchildren, and also valuable in teaching children

⁶⁵ Leprosy Mission, 119/4, Letter from M. Laing, April 1935; Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children’s Home, 1935; RCA, Kumi Annual Report, 1947.

⁶⁶ RCA, Kumi and Ongino Annual Report, 1946.

⁶⁷ Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children’s Home, 1935.

⁶⁸ Leprosy Mission, 119/4, Letter from M. Laing, 9 November 1936.

⁶⁹ Rogers and Muir, *Leprosy*, 247.

⁷⁰ RCA, Kumi and Ongino Annual Report, 1951.

the manual dexterity that they would need in their future as labourers.⁷¹ It is perhaps unsurprising then that at Kumi, cultivation was particularly lauded for its ability to bring about mental and physical health in the child patients. Moreover the missionaries believed it was appropriate labour for Africans, and would prepare children for their future as agricultural cultivators.⁷²

A Transformation of the Mind and Soul: From Healthy Child to Civilised Adult

In addition to encouraging the mental and physical transformations perceived necessary for a child leprosy patient to achieve health, the CMS missionaries of Kumi endeavoured to cultivate in their patients an improvement of the mind and spirit that would not only preserve their bodies, but also give their lives meaning and usefulness. Missionaries hoped to sharpen the children's minds, so that they could reach an appreciation of the values of Christianity and civilisation, which they would then internalise and sustain throughout the course of their lives, acting as a shining example to others. This was an entirely achievable goal, for they wrote occasionally of patients whose minds were changed drastically by the years that they spent at Kumi. For example, 'A keen, intelligent lad called Semu...was taken into the children's home at Kumi an ignorant little leper boy. In that Christian atmosphere he developed a keen mind and a healthy body'.⁷³ Not that a healthy body was a prerequisite for this mental improvement; Miss Laing wrote of a number of children who 'have been in the Home for four years and there is very little improvement in their physical condition, but mentally they are brighter, and more intelligent'.⁷⁴

From the missionaries' perspective, the most valuable change that a child leprosy patient could make was conversion to Christianity. Children with leprosy were perceived as

⁷¹ J. Welshman, 'Child Health, National Fitness, and Physical Education in Britain, 1900-1940', in M. Gijswijt-Hofstra and H. Marland, *Cultures of Child Health in Britain and the Netherlands in the Twentieth Century* (Amsterdam, 2003), 66, 72.

⁷² Chisolm, 'Education, Punishment and the Contradiction of Penal Reform', 35.

⁷³ Birmingham, CMS/H/H5/E2, MMA Year in Review, 1938-39.

⁷⁴ Leprosy Mission, 119/4, Letter from M. Laing, 12 March 1934.

particularly good targets for evangelising efforts. As Miss Laing wrote, ‘I pray that before the time of the next Annual letter comes round, many little ones may have received the benefit of our happy life here – much of the disease cured, not only their bodies made more fitted for service, but their souls [?] for His greater glory’.⁷⁵ Above all, missionaries felt that Christianity was responsible for the improvements of the mind and spirit that were so integral to the healing of leprosy. As another CMS missionary wrote: ‘Vividly picture the joy that is daily coming to these little sufferers in the Kumi Home as they not only receive healing of their bodies, but hear and receive the engrafted Word which is able to save their souls’.⁷⁶ Ideally this special bond with Christianity would endure throughout the children’s lives, in spite of the challenges their beliefs would face when they returned home.⁷⁷

The malleability of youth favoured a child leprosy patient’s lasting relationship with Christianity, as they were being introduced to God ‘at an age when impressions are so easily formed which make a man their whole lives’.⁷⁸ Certainly child patients at Uganda’s leprosy settlements were far more likely to convert to Christianity than their adult counterparts.⁷⁹ This is not to suggest that the missionaries felt absolutely secure in the value of conversions that occurred at a young and impressionable age; on the contrary, the lady missionaries of Kumi occasionally expressed concerns that children who were too young, or of too backward a mindset, and could not understand Christianity properly. Only children ‘old enough to understand’ were placed under religious instructions, and baptism was only allowed when patients had proven over time that they were living up to the values of civilisation and Christianity in action.⁸⁰ Miss Laing wrote:

⁷⁵ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

⁷⁶ Leprosy Mission, 119/4, Letter from E.B. Bull to Anderson, Secretary, Mission to Lepers, 17 July 1934.

⁷⁷ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1941.

⁷⁸ Birmingham, CMS/G3/AL Marjorie Atkinson 1931-32.

⁷⁹ This statement is based on the number of conversions noted in adult and child patient records at Buluba Hospital and on the annual reporting of Baptisms and Confirmations at Kumi and Ongino.

⁸⁰ Leprosy Mission, 119/4, Letter from M. Laing, 9 November 1936.

I knew, as I sat and watched these Boys and Girls from a distance that they were indeed in earnest as they came forward and gave themselves to the Lord Jesus Christ. We do not, in this school, allow our boys and girls to enter into baptism easily. As they live with us, we are able to note if their customs are good, and if they are really trying to live up to what they want to be.⁸¹

Christianity might be a source of joy and healing, but it would only truly be able to give the lives of child leprosy patients meaningfulness if their minds were improved enough to understand it fully.

The greatest hope that Teso's CMS missionaries had for Kumi was that the child patients who truly embraced Christianity would act as beacons when they returned symptom-free to their villages, spreading the light of Christianity and civilisation. As one of the Kumi missionaries wrote, 'It is our earnest hope and prayer that they will prove to be witnesses for Christ in their villages'.⁸² And as a nearby CMS reverend wrote, 'It is through such agencies as the Children's Home that the Light of the Gospel of Jesus Christ will shine out, and that they [the Iteso] will see the light of the knowledge of the glory of God in the face of Jesus Christ'.⁸³ The missionary ladies occasionally wrote of their work at Kumi as a struggle over the ignorance and disease of Ugandans, where victory was the cure, evangelisation, and education of children with leprosy, who could then go out and spread that civilisation to others:

What a warfare, and what a triumph!...Fifty-two boys and girls were discharged symptom free, all without deformity, and all of them baptized Christians—potential witnesses for Christ in their own villages. Equipped to face life and to be channels of life to their own people: this is triumph indeed over a "vampire" form of suffering.⁸⁴

The missionaries hoped children would spread both eternal life through the salvation of the soul, and life on earth by passing on their newfound knowledge of health and hygiene.

Indeed, some children's institutions in England also envisioned children as 'health missionaries' who would take the lessons of hygiene they learned back to their families when

⁸¹ Leprosy Mission, 119/4, Letter from M. Laing, February 1938.

⁸² Leprosy Mission, 119/4, Letter from M. Laing, 9 March 1940.

⁸³ Leprosy Mission, 119/4, Letter from Bull to Anderson, Secretary, Mission to Lepers, 17 July 1934.

⁸⁴ Leprosy Mission, 118/16, Letter from Lang to Anderson, Secretary, Mission to Lepers, 29 June 1933.

they were released.⁸⁵ At this time, children were also becoming increasingly important as ‘go-betweens’, who could establish a dialogue between the mission or colonial state and their families.⁸⁶

Kumi was never intended as solely a medical institution, and indeed it was meant to perform the same function as CMS schools, with the shortfalls of illness made up for by the sincerity of conversion and the totality of Christian influence in a boarding school with rare holidays.

Ideally, a patient discharged from a leprosy settlement should be a missionary to his own people. Far from being a parasite on the community (in Uganda lepers are outcasts) he should be a leader of the community. In short, a patient discharged from a leprosy settlement should have as great a missionary potential as a man sent out from a teachers’ training college.⁸⁷

This same missionary, Dr. Wheate, sent by BELRA to take over the settlement upon Miss Laing’s retirement in 1947, even wrote that ‘it seems pointless to cure them of leprosy if they are going to return to their homes untouched by the Christian message’. Thus the leprosy patient as evangeliser provided a strong motivation for leprosy work.⁸⁸

In addition to moulding child leprosy patients into Christian adults whose lives were made meaningful by religion, the missionaries of Kumi endeavoured to give the children a ‘useful’ future, through education and other forms of training, which would in turn aid them in integrating into their former or future communities. As CMS nurse Miss Kent put it, ‘Here they were learning to be useful to each other and to themselves, learning to read and write, learning to build and cultivate, learning, if the time should come, to take their part once more in the life of the community...They do learn to make their lives worth while’.⁸⁹ As an example of this assertion, she tells the story of the settlement’s salvation of one young man, a teacher:

⁸⁵ Bryder, ‘Wonderlands of Buttercup, Clover and Daisies’, 81.

⁸⁶ Beinart, ‘Darkly through a Lens’, 237.

⁸⁷ Birmingham, CMS/G3/A10/m1A, Letter from Dr. Wheate to Hooper, 9 June 1949.

⁸⁸ Birmingham, CMS/G3/A10/m1A, Letter from Dr. Wheate to Hooper, 9 June 1949.

⁸⁹ Birmingham, CMS/G3/AL Adelaide Kent 1938.

FINEKANSI, our head teacher, is an example of this. He had taken his training as a teacher and had passed, had received his certificate the goal of years of work and study, full of plans for the future, then his hopes dashed he was found to be a leper, it isn't difficult to imagine it, is it? Had he remained in his village what would have happened, he would have settled to the life of a "Mulwade" sick person unable to do anything, depressed, unhappy. He came to Kumi, he was very depressed and unhappy at first, of course, but presently he found his job again, he took up life afresh, he found he could still do something, and used his training to teach and help his fellow-sufferers.⁹⁰

Through entering leprosy settlement, Finekansi was transformed from a depressed sufferer of leprosy to an admirable Christian with a 'worth while' life of helping others. This was the future that the missionaries imagined for their child leprosy patients, whether they stayed to help their fellow leprosy sufferers, or left to put their Christianity and training into practice elsewhere. For, 'Is it not grand to see these young people who were once Lepers, strong and well, taking their places in the world, and learning to be self-supporting, and helping others as they have been helped?'⁹¹

Moulding Citizens of the British Empire

The British civilising mission, which was such a large justification for colonialism and missionary work, was premised upon the idea that the British were inherently superior to the people of the tropics, and that it was therefore their right and responsibility to promote those character traits that defined the ideal British citizen, for the benefit of their 'primitive' colonial subjects. For the CMS missionaries at Kumi, the civilising mission was about moulding young leprosy patients into adults who were Christian, educated, and embodied the character traits that defined the British, and specifically the English, as a superior nation – at least to the extent that they believed supposedly inferior Ugandans capable. Much like the residential charitable institutions in Britain that strove to remake poor children by separating them from their parents and placing them in a new domestic environment, the CMS missionaries used Kumi to try to create imperial citizens, as British in character as possible,

⁹⁰ Birmingham, CMS/G3/AL Adelaide Kent 1938.

⁹¹ Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

but prepared to undertake their subordinate imperial status.⁹² While the missionaries were more apt to describe success in terms of patients attaining Christianity, rather than citizenship, the character traits that they endorsed, such as ‘Obedience, Gentleness, Love and Service’, were the same as those promoted by their supposedly secular colonial counterparts.⁹³ These character traits were particularly well embodied by the principles of the Boy Scout and Girl Guide movements, which were started at Kumi and considered especially ‘useful activities’ for their transformative power.⁹⁴

Service, and by extension love, was particularly strongly emphasised by the missionary ladies, who deemed it such a positive characteristic that it was often linked to descriptions of intelligence.⁹⁵ One young woman, Priscilla, who spent five years in treatment at Kumi before being released symptom-free and going to Mengo to train in the CMS nursing school, was reported to be ‘exceptionally good, especially in her thought for others. And is this not the spirit which we are aiming at, thinking for and serving those in need?’⁹⁶ Priscilla’s story is one example of many in which the missionaries chose one young man or woman, a former child patient, who early showed ‘a real desire to love and serve Jesus’, and followed a vocational path that would allow her to express that love through service to others.⁹⁷ The missionaries also wrote occasionally of large groups of children displaying their devotion through a ‘labour of love’: usually carrying stones and bricks for a new building.⁹⁸ An ‘eagerness to be helpful’ was often mentioned and lauded, as were patients’ endeavours to use the education and training that they had acquired in the settlement for the

⁹² Murdoch, *Imagined Orphans*, 41-42; L. Rose, *Erosion of Childhood: Child Oppression in Britain, 1860-1918* (London, 1991), 134.

⁹³ Leprosy Mission, 119/4, Letter from Laing, April 1935.

⁹⁴ Birmingham, CMS/G3/AL Adelaide Kent 1938; T. Parsons, *Race, Resistance, and the Boy Scout Movement in British Colonial Africa* (Athens, 2004), 31.

⁹⁵ Leprosy Mission, 119/4, Letter from M. Laing, 12 March 1934; Leprosy Mission, 119/4, Letter from Laing, April 1935.

⁹⁶ Birmingham, CMS/G3/A10/m1A, Letter from Laing, January 1942.

⁹⁷ Laing, ‘Children’s Leper Home’, 244.

⁹⁸ Lang, ‘Notes from the Children’s Leper School’, 7.

sake of other leprosy patients.⁹⁹ The greater the personal sacrifice of the patient, the greater the praise that the missionaries heaped upon them. For example, Miss Laing was ‘filled with admiration’ for the first Kumi girls who stepped forward to train for dispensary work, overcoming the ridicule of their peers in their desire to serve others.¹⁰⁰ She specified that ‘It is the Christians who volunteer, and probably it is because they are Christians that they are prepared to help their suffering neighbours’.¹⁰¹

The service encouraged or required by the missionaries could also link the children of Kumi to the British Empire in a far more tangible way: through charitable donations. However small their own earnings, the children were encouraged to think of those who were suffering in other parts of the Empire. For the leprosy patients of the Lui settlement in Sudan: ‘The children had been earning money by doing little tasks, and even the smallest had 2 cents...ready to put into the collection plate’.¹⁰² On this occasion, the children would have been forewarned that a charitable collection would take place, and encouraged to bring some of their money with them to the prayer service. In nineteenth-century Britain children became increasingly involved in charity work, and in pushing the children of Kumi to donate to charitable causes, the lady missionaries were probably thinking of the children in England who raised so much money for missionary societies, in particular.¹⁰³

Service was also an important component of citizenship, and the British felt that the Boy Scout and Girl Guide movements would be particularly effective tools for teaching young Africans the importance of charity, as has been discussed by other historians of Scouts

⁹⁹ G. Hopkins, ‘A Kenya Picture’, *BELRA Quarterly* (April 1946), 27; Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

¹⁰⁰ Laing, ‘Children’s Leper Home’, 246.

¹⁰¹ “‘The Healing of His Seamless Dress’: Annual Report Number’, *Mission Hospital*, 41.476 (September 1937), 211.

¹⁰² Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children’s Home, 1935.

¹⁰³ F. Prochaska, ‘Little Vessels: Children in the Nineteenth-Century English Missionary Movement’, *Journal of Imperial and Commonwealth History*, 6.2 (1978), 103.

and Guides in the Empire.¹⁰⁴ Kumi's missionaries made a point of connecting their Scouts and Guides to other troops around the Empire, and in England particularly. They wrote letters about Kumi's troops for circulation among Boy Scouts and Girl Guides in Britain, and there was even a Girl Guide troop in Cheam, England, that sponsored Kumi's Guides. During World War II the missionaries made a particular point of telling the leprosy patients about the troubles facing Boy Scouts in England: 'The Scouts and Cubs have been told quite a lot about Scouts and others who have been bombed out of their homes, and of the refugees who have come from other countries, and they are really interested and keen to do all they can to help'.¹⁰⁵ Accordingly, Kumi's Scouts raised a collection and donated money to the distressed Scouts Fund in England, as did the Guides for their own distressed counterparts in England:

These invalid Guides are very keen, not only on the actual guide work but in carrying out the real principle of all guiding, that of helping other people not only in this Home amongst their fellow sufferers, but in other parts of the world.

These Guides, too, are trying to do their share to help in the War Effort. They have cultivated their Cotton Patch, the proceeds of which has been given to the War Fund.

The great event from them last year was the visit of their Chief Guide, Lady Baden Powell. On this occasion the Guides performed a topical pageant, showing various aspects of women's war work in England. The Guides then presented Lady Baden Powell with a cheque for Shs. 30/- which they had earned entirely themselves. And at their own request, the money was to be used for distressed Guides in England. Quite a number of these Guides are without fingers or toes.¹⁰⁶

This quotation demonstrates not only the emphasis of Kumi's Girl Guide movement on service, but also the extent to which the Guides were used as a vehicle through which to make connections to England. Analogies between the experiences of Ugandan Guides and English Guides were made especially frequently during wartime, when the suffering of Kumi's Girl Guides, 'without fingers or toes', could be construed as no more than the plight of some of Britain's children. The Guides were also active in Service to other causes, for example

¹⁰⁴ Parsons, *Race, Resistance, and the Boy Scout Movement*, 31; A. Warren, 'Mothers for the Empire?' in J.A. Mangan, *Making Imperial Mentalities: Socialisation and British Imperialism* (Manchester, 1990), 106.

¹⁰⁵ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1941.

¹⁰⁶ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1941.

raising money for Lord Baden Powell's Memorial Fund on Poppy Day, and doing community work for Red Cross Day.¹⁰⁷

Obedience, unlike love and service, was mentioned relatively rarely by the missionaries, and it might therefore be fair to assume that it was the characteristic that they were least successful in teaching. On rare occasions, however, the missionaries would write of how 'orderly' the children were at Church services, and outside visitors would comment on the 'marvellous discipline' of the children at Kumi.¹⁰⁸ The Guide and Scout movements were a supplement to endeavours to instil respect for authority in the child leprosy patients of Kumi; the Scout Law called specifically for boys to be loyal and obey.¹⁰⁹ This discipline and loyalty was not only a demonstration of commitment to Christianity, the Scouting or Guiding movement, and the authority of the missionaries within the settlement, but also a preparation for adult life as a citizen in the British Empire.¹¹⁰ Obedience was taken very seriously by the colonial government in Uganda; when the CMS applied for permission for two young men, former Kumi patients, to go for teacher training, a government medical officer recommended against one of the boys because he was 'not very intelligent' and 'said to be disobedient'.¹¹¹ In attempting to instil a respect for the authority of the civilised British and Ugandans, the missionaries were consciously preparing the children for lives as subordinates in the British Empire.¹¹²

Some of the other adjectives commonly used in positive description of child leprosy patients were: brave, courageous, determined, dependable, intelligent, keen, quick, persevering, loving, faithful, thoughtful, observant, useful, industrious, excellent worker, and smart (in appearance). A quickness and interest in learning was particularly highly valued, as

¹⁰⁷ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report 1944.

¹⁰⁸ Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children's Home, 1935; Hopkins, 'A Kenya Picture', 26.

¹⁰⁹ Parsons, *Race, Resistance, and the Boy Scout Movement*, 55, 259.

¹¹⁰ Warren, 'Mothers for the Empire?', 100.

¹¹¹ UGNA, 4001, Letter from DMS to Teso Acting Chief Secretary, Campbell, 5th November 1938.

¹¹² Murdoch, *Imagined Orphans*, 63.

were enthusiasm and hard work. When Dr. Wheate wrote of the mission's success in saving and educating one boy who had nearly died of leprosy, his highest praise was: 'When he is sent on an errand he runs'.¹¹³ When he wrote of a teenage patient who wanted to learn the carpentry trade, 'wild horses would not drag him from the carpentry shop'.¹¹⁴ This praise was consistent with the notion common in child welfare institutions in Britain, that work and perseverance were a child's best assets in the struggle to avoid the fate of his or her indigent parents.¹¹⁵ Given the similarity in British middle class views towards the lower classes in Britain and the colonial subjects in the Empire, that both the poor and the 'savages' were lazy, backwards, and a danger to their innocent children, it is unsurprising that Kumi's missionaries saw a solution in industriousness and dedication, and made a virtue of it.

Responsibility and dependability were prerequisite to any kind of advance within the hierarchy of the settlement, and they were seen by the missionaries as traits that could only be learned by a minority of Kumi's young patients. Particularly responsible and intelligent young men and women were selected to be the heads of children's dormitories and to undertake specialised training that would give them greater abilities and status within the settlement. Training as a nurse, midwife, or teacher required a high standard of behaviour, as the mission had to find the resources to send these young men and women away from Kumi for schooling. If they ever failed in upholding these standards, their education was terminated:

I have 2 leper girls training as leper nurses. They were both doing extremely well, but one, I am sorry to say, has not fulfilled our expectations, so another is chosed [sic] to take her place. Zerida the remaining helper is doing a really good work and is showing an intelligent interest amongst the sick girls.¹¹⁶

Reading between the lines, it seems most likely that the errant trainee nurse proved to be undependable in maintaining the behaviour expected of a civilised Christian. Praise for

¹¹³ *BELRA Quarterly* (July 1950), 50.

¹¹⁴ H. Wheate, 'Here and There', *BELRA Quarterly* (October 1951), 76.

¹¹⁵ Murdoch, *Imagined Orphans*, 121.

¹¹⁶ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

dependability went hand in hand with praise of other characteristics here mentioned as desirable, particularly that of service. The Scout and Guide movements were also seen as effective tools for engendering responsibility in African youth, and at Kumi, Girl Guides in particular were praised as dependable and capable.¹¹⁷ Four members of the original Guide troop, founded in 1937, went on to train as nurses at Mengo Hospital.¹¹⁸

Courage and fortitude were also seen as desirable characteristics in Christians and citizens of the British Empire. The stoic endurance of suffering was particularly admired by the missionaries:

Each child undergoes a regular course of treatment – and Tuesday morning alas! Is [?] a day of dread – HYPODERMIC INJECTIONS !!! – To give 148 takes no little time, and I must confess I am quite as thankful as the children when this is all over. They are exceptionally good – absolute little “Britons” if one may use this term of our small African kiddies!¹¹⁹

Another missionary also wrote: ‘They have one black day in the week, and that is injection day, but some of them are very brave and really keen to get better, for I think they are beginning to realize all that this treatment means to them’.¹²⁰ The high praise of comparing Ugandan children to ‘little Britons’ was about more than bravery; it also celebrated obedience in the face of suffering and a growing awareness of the value of biomedicine. ‘Crippled’ Girl Guides were especially likely to be recommended for the Fortitude Badge, on the basis of their ‘courage and perseverance and cheerful outlook, which...has been an encouragement...to all the children in the Home’.¹²¹ It might even be said that the attempt to be cheerful was perceived as a virtue; one visitor to Kumi reported that ‘The Kumi Leper Colony, Uganda, is

¹¹⁷ Parsons, *Race, Resistance, and the Boy Scout Movement*, 31; Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

¹¹⁸ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report 1944.

¹¹⁹ Birmingham, CMS/G3/AL, Marjorie Atkinson 1931-32.

¹²⁰ Lang, ‘Notes from the Children’s Leper School’, 7.

¹²¹ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report 1944.

one of the brightest and yet the saddest of places. Sad because of the terrible disease. Bright because everyone is trying to be cheerful – even the worst cases’.¹²²

Becoming a citizen of the British Empire was not just about the development of certain character traits, but also about embracing the imperial mentality.¹²³ Like children in Britain, the children of Kumi performed imperialism through physical activities that expressed the ideologies of British nationalism, for example through drill, singing the national anthem, and the raising of the British flag.¹²⁴ In Britain, flag-raising ceremonies and drills were meant to inculcate in children a sense of national pride and responsibility, and many schools incorporated symbols of empire or nationalism into drill formations, such as children making up a living Union Jack or a Christian crucifix.¹²⁵ At Kumi, too, the children were asked to put on displays of imperial pride on special occasions such as Empire Day, a war remembrance ceremony, or the visit of a distinguished colonial officer. Another example was the organisation of an exhibition of leprosy patients’ handwork in 1947, to which the lady missionaries invited local chiefs and CMS missionaries from around the diocese to view the handwork and attend the prize giving ceremony.

As they (guests) were seated on the verandah at the back of the Dispensary, strains of a band as yet unseen were heard, Soon from behind the Dormitories appeared the Scouts, Guides, and Rangers, who marched smartly up the centre of the compound, and halted at the Flag Staff and then all sang the National Anthem in English. Then from the hidden corners out rushed the Brownies and Cubs, and made their Grand Salute. It was a very pretty and colourful sight. The Scouts and cubs in their Khaki suits and yellow scarves. the Guides in a very pretty blue uniform with green and red ties, the Rangers in a darker blue with red scarves, and the Brownies in their little brown uniforms with bright yellow ties.¹²⁶

¹²² ‘Leper Colony’, *Empire Digest* (October 1946), 9.

¹²³ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

¹²⁴ A. Bloomfield, ‘Drill and Dance as Symbols of Imperialism’, in J.A. Mangan (ed.), *Making Imperial Mentalities: Socialisation and British Imperialism* (Manchester, 1990), 74.

¹²⁵ Bloomfield, ‘Drill and Dance’, 74-82.

¹²⁶ Leprosy Mission, 119/5, ‘Exhibition of Handwork’, August 1947.



Figure 17: 'Scouts at Kumi', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing.

On such occasions, the bodies of Kumi's child leprosy patients were displayed as a sign of the intentions and successes of the missionaries' civilising mission.¹²⁷ With a Union Jack on the flagstaff; Scouts and Guides flags carried by the troops; the British national anthem sung in English, though most of the children did not know the language; a band; and Scouts, Guides, Cubs, and Brownies in the uniforms worn by children across the world, Kumi's children were performing the ideology of empire (see Figure 17).

Drill was also a part of the Kumi students' daily timetable, and one of the only classes that the missionaries taught themselves. Drill was the marching of students into specific formations, with the accompaniment of dance, folk, or military music. Its emphasis on physical repetition and conformity was meant to encourage discipline, physical fitness, and devotion to the Empire, and across Britain drill was regarded as an important tool for building

¹²⁷ Dirks, 'For the Youth', 230.

children's national character and moulding them into citizens of empire.¹²⁸ Displays of drill, or physical exercise, were also put on for special occasions, and Scouts and Guides in particular were taught a variety of formations with which they could demonstrate their devotion to the Empire.¹²⁹

From all their descriptions of the young leprosy patients at Kumi, it is evident that the missionaries were endeavouring to promote certain characteristics in the children: the qualities of a good Christian and Briton, who bore suffering with fortitude, served others and remained steadfast in faith, and wished to learn more of the trades and values that civilisation had to offer. Indeed, British colonial governments in Africa left the responsibility of education to missions, not just because of financial expediency, but also because they believed in the value of the lessons of morality and discipline that were taught in mission institutions.¹³⁰ At Kumi, in particular, these characteristics of Christianity and Britishness, so assiduously promoted by the missionaries, were a great part of the colonial government's financial support and interest in leprosy settlements in Uganda. As visiting leprologist Edward Muir wrote, 'Here a goodly company of over 300 children of leper parents are growing up to become healthy and useful citizens'.¹³¹

The Reality of Life within the Kumi Leprosy Settlement

While the CMS had a grand vision for the spiritual, physical, and civic transformation of all leprosy patients under their care, in impressionable children, separated from their parents, they perceived a much easier target for social engineering. Historian Lydia Murdoch has suggested that since the 1870s, 'the implicit goal of many children's institutions was to

¹²⁸ Bloomfield, 'Drill and Dance', 82

¹²⁹ Leprosy Mission, 119/4, Letter from M. Laing, April 1935; Leprosy Mission, 119/5, Gertrude Hopkins, 'Leper work at Kumi and Ongino', 1945.

¹³⁰ Parsons, *Race, Resistance, and the Boy Scout Movement*, 40.

¹³¹ 'The Healing Fellowship', *Mission Hospital*, 43.500 (February 1939), 238.

create an alternative world to the existing culture'.¹³² This was as true of children's institutions in the colonial world as it was of institutions for poor children in Britain, and the common factors that went into these attempts were the civilising mission, the desire to save children, and controlling tendencies.¹³³ Yet as in Britain, the alternative reality that missionaries envisioned could not simply be implanted upon the children of Uganda. Control over the lives of child leprosy patients was a constant negotiation between the CMS missionaries, the settlement's Ugandan staff, the children's families, and the children themselves.

The Mission Endeavour to Create an Alternate World

When CMS Dr. Wiggins opened Kumi in February of 1930, the settlement housed 25 children who had previously been treated as out-patients at leprosy centres around Teso. Admitting children of all ages, the settlement gradually grew in size until it reached a plateau of about 400 patients by 1941. Most children were kindergarten age and older. Leprosy often had a long incubation period, and it was therefore uncommon for very young children to develop symptoms of the disease, even if they had been infected by a parent in infancy, as was common. In the 1930s, the majority of patients entering the settlement were Iteso, but as the settlement grew in size and reputation, children came from across Uganda to be admitted for leprosy treatment. In 1941, the settlements' ethnic breakdown of children versus adults was relatively similar, but with slightly higher percentages of children from nearby areas: Iteso (72% children and 67% adults), Bagwere (19% children and 10% adults), Badama (10% children and 5% adults), Bagishu (5% children and 9% adults), and Acholi (2% children and 5% adults).¹³⁴

¹³² Murdoch, *Imagined Orphans*, 164.

¹³³ Dirks, 'For the Youth', 43; Ocobock, 'Coming of Age in a Colony', 149.

¹³⁴ SDA, X/NAF/9, Note from Dr. Wheate to DC Teso, May 1941.

No ethnic breakdown of child versus adult patients is available later in the decade, but in a 1949 survey of Kumi's child patients and Ongino's adult patients, Dr. Wheate recorded that the four largest ethnic groups in the settlement were: 39% Teso, 25% Bagishu, 11% Lango, and 8% Acholi (see Map 2).¹³⁵ It is probable that the greater the distance to the settlement, the less likely it was that parents would part with their child for treatment. However, anecdotal records from the missionaries do suggest that there were a substantial number of Lango and Acholi children in the settlement, and in the 1940s the missionaries had to start offering schooling in three languages: Iteso, Lango/Acholi, and Luganda.¹³⁶

Unlike the nearby adult settlement, where as many as half of the leprosy patients were disabled, amongst the children, fewer than 15 percent suffered from visible disability.¹³⁷ This was because in the children's settlement the missionaries focused on taking in early cases. Before the arrival of sulphone drugs in the settlement in 1948, children would generally have to stay in the settlement four to five years: the first few years were for treatment, and the last year or two they were kept under observation, lest symptoms reoccur.¹³⁸ This excepts those children who 'absconded', or withdrew them from the settlement before they were paroled. A minority of the child patients, between two and seven percent annually, were so disabled by the disease that they could never be considered 'cured'.¹³⁹ Between the ages of 16 and 21, these young men and women were transferred to the adult leprosy settlement at Ongino, ostensibly to remain for the remainder of their lives.

For the majority of the time period under study, from 1932 to 1947, Kumi was organised in a loose hierarchy, with the CMS nurse Laing as the superintendent. Slightly beneath her in authority was another CMS nurse, Miss Kent. Next in the hierarchy was

¹³⁵ RCA, Kumi Annual Report, 1949.

¹³⁶ RCA, Kumi Annual Report, 1951.

¹³⁷ Leprosy Mission, 119/4, Letter from A. Downes-Shaw to Anderson, Secretary, Mission to Lepers, 8 June 1934; Laing, 'Children's Leper Home', 248.

¹³⁸ C.A. Wiggins, 'Retrenchment', *Mission Hospital*, 445 (February 1935), 34.

¹³⁹ These numbers are based on annual reports for the Kumi Leprosy Settlement from 1941-1948.

Omwami (headman) Onesimus Pusimo, whose official title was ‘Senior Native Medical Assistant’ of Kumi. Onesimus was a Bagandan medical orderly who was originally trained at the CMS Mengo Hospital, and who started his work at Kumi when it opened in 1930. ‘A splendid Christlike character’, former Boy Scout, and recipient of the King’s Jubilee Medal, Onesimus was Miss Laing’s ‘right hand in everything’, trusted to look after many of the settlement’s affairs and help raise its children.¹⁴⁰ Beneath Onesimus were a number of medical orderlies, nurses, teachers, and evangelists, most of whom were former leprosy patients who had converted to Christianity, received training either within or without the settlement, married a fellow former patient, and settled down to live at Kumi. Below them were a number of favoured young men and women who were being trained by the Ugandan staff and the missionaries for future leadership roles. In addition to those with formal training and positions of authority, the missionaries chose several young men and women of responsible and Christian character to head each dormitory, and supervise the younger children within. Dormitories were divided by gender, and then sub-divided based on the type of leprosy from which the patient was suffering.¹⁴¹ Finally, at the bottom of Kumi’s hierarchy were the remainder of the child leprosy patients, aged from infancy to 16, 18, or 21 years, depending on current transfer policy.

One aspect of the CMS missionaries’ attempts to create in Kumi an alternate world to the Uganda that they perceived as so primitive and backward was the imposition of a strict daily timetable, replete with a variety of socially, spiritually, and physically beneficial activities. After waking in the early morning, the children would clean their dormitories and compound, bathe, or go into the gardens to cultivate for an hour. They had early morning tea and then attended a prayer service in Kumi’s small chapel, following which they would go to their classrooms for schooling. Each class was set on a rota for medical treatment, and if any

¹⁴⁰ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

¹⁴¹ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

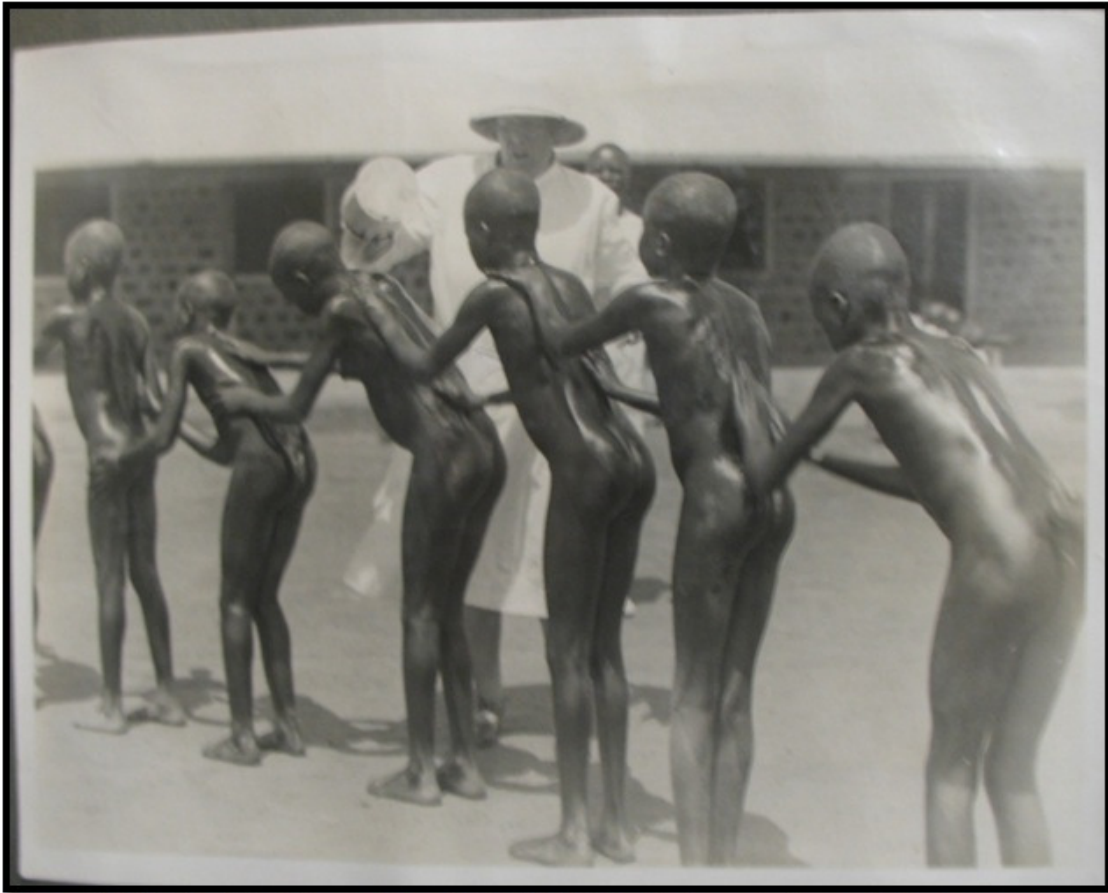


Figure 18: 'Rubbing Drill', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing.

children needed daily medical care, for instance the dressing of ulcers, they would absent themselves from class during the allotted time, to minimise disruption. Once a week, the entire class would go to the dispensary and wait their turn for an intradermal injection of chaulmoogra oil, which was one of the primary biomedical treatments for leprosy. Twice weekly the children would also complete rubbing drills, helping each other to coat their backs with hydnocarpus oil as further biomedical treatment (see Figure 18). After 8 A.M. prayers, until 3 P.M. in the afternoon, the children had a 'properly mapped out Time Table of lessons' and drill, with a break for dinner.¹⁴² At 3 P.M. came 'the best time of the day, games, of which football is the most popular'.¹⁴³ Activities such as netball, skipping, country dancing, Boy Scouts, and Girl Guides were also available during this time. There was also a

¹⁴² Birmingham, CMS/G3/AL Marjorie Atkinson 1931-32.

¹⁴³ Kent, 'Leper Children's Home', 163.

recreation ground with two see-saws, a swing set, a tennis court, and a football field, and musical instruments for the children to play with, such as mouth organs and a bugle. After recreation, the children would again go into the fields to cultivate, and for most children the day closed with supper and evening prayers. Baptism and Confirmation classes were also available for those children who wished it.

For older, 'senior' children, the schedule was slightly different. Instead of attending class in the mornings, they went about their various jobs. By 1942, 'All work such as Gardening, Building in Cob or making Cement Blocks, White Washing, Painting, Cooking, Cultivating, Cleaning and Herding, is done by our own leper trained boys and girls'.¹⁴⁴ Much of the new building was completed by teenage patients, for which they received a small wage.¹⁴⁵ The youths were released from work at 1 P.M., and then at 2 P.M. 'their religious instruction is continued by making it possible for them to attend classes'.¹⁴⁶ In the evenings, they had the additional options of attending a weekly Bible class, and thrice weekly supplementary classes, where the students were given the opportunity of learning English and listening to lectures on nursing and dispensary work.

School classes were divided by gender, and then 'according to the ability and condition of the child, rather than age'.¹⁴⁷ The missionaries focused these classes on the acquisition of knowledge that they considered to be practical for Ugandan children: 'the things that matter'.¹⁴⁸ The lady missionaries and Ugandan staff decided what kind of life each child patient was fit to lead, and educated them accordingly. For most children:

The school has aimed at teaching children at least to read, write and count; to become acquainted with scripture, to use their hands and to work out-of-doors, especially at the elements of agriculture; while a certain number of them are also learning a trade, and most of the girls are having a grounding in needlework.¹⁴⁹

¹⁴⁴ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1941.

¹⁴⁵ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

¹⁴⁶ Laing, 'Children's Leper Home', 246.

¹⁴⁷ RCA, Kumi Annual Report, 1946.

¹⁴⁸ Birmingham, CMS/G3/AL Rosa Langley 1932-33.

¹⁴⁹ RCA, Kumi Annual Report, 1951.

The missionaries of Kumi were content if the majority of their young patients learned enough reading and writing to connect to Scripture, enough arithmetic to handle their money, and the agricultural skills they would need for their future livelihood. Hygiene, drill, and singing supplemented the school curriculum.

Capable and Christian youths were encouraged to learn trades, and the rest of the children were encouraged to learn handwork. Handwork included knitting, sewing, needlework, making bead necklaces, baskets, mats, ropes, and more, and combined an emphasis on British and 'traditional' Ugandan techniques. The missionaries accounted handwork as 'a most popular subject' in school, and one at which Ugandans, and especially girls, would be naturally capable.¹⁵⁰ In 1947, Miss Laing put on a Handwork Exhibition at Kumi, which was described by a visitor:

We were amazed at the quality and variety of the work. All this work was done entirely by the African patients themselves, there was no assistance from the European Staff at all...The number and variety of [exhibits] convinced us of the keenness with which the idea had been received, and the originality of some of the work done by patients who had been many years without contact with the outside world, did show that in spite of this they were all keenly alive, and had not become dulled by their isolation, or lost touch with their native occupations.

On two side of the room were arranged specimens of sewing of all kinds including simple frocks...and some of a more up-to-date style...The sewing on some of these was so neat that at first they appeared to have been made by machine, so even were the rows of stitching...The many examples of Basket-work were delightful and were made by Boys and Girls, they were exceptionally well done....Two enterprising boys had made a cup and saucer and a teapot, all out of sisal, also a chair stool and cot.¹⁵¹

'Native occupations' such as basket-work and weaving were evidently innate Ugandan knowledge, as the children were still capable of creativity in handwork after 'many years without contact with the outside world'. The missionaries and Ugandan handwork teachers took this supposedly innate ability and supplemented it with British handwork occupations, like needlework and the sewing of Western ladies' clothes. This fusion between 'traditional'

¹⁵⁰ RCA, Kumi Annual Report, 1946.

¹⁵¹ Leprosy Mission, 119/5, 'Exhibition of Handwork', August 1947.

Ugandan and ‘civilised’ British handwork could sometimes be seen quite literally, as with the cup, saucer, and teapot made of sisal. All of the children were taught to sew, so that they could make their own clothes, but in keeping with the CMS’ emphasis on the model of domestic virtue, women were ‘educated to a degree suitable for their conditions in life’ and especially in the “‘Home Industries” e.g. mat making, basket making, sewing etc’.¹⁵² The CMS believed that Ugandans were very capable of working with their hands, could expect a future doing this, and prepared boys and girls accordingly. Those few who they judged more capable and dependable were given the opportunity to pursue more intellectually demanding careers, such as in teaching and nursing.

In their endeavour to socially engineer an alternate world that combined the best of Ugandan ‘tradition’ with the civilised customs of Britain, the missionaries of Kumi used certain measures of control to implement the curriculum and behavioural adaptations that they envisioned. The apparent order and discipline that the missionaries were able to maintain at Kumi is quite unlike that of any other mission children’s institution in Uganda. In a very few letters, the lady missionaries of Kumi referred to ‘orderly rows of children’ who were waiting or ‘sitting in reverent silence’, whether for their weekly medical injections or the dedication of the settlement’s new chapel.¹⁵³ Pictures, especially those from the private collection of Miss Laing, demonstrate this orderliness in far greater scope. In dozens of photographs, the children of Kumi stand in orderly lines; in fact, it seems that almost any activity they were to undertake, from collecting water to entering the chapel for prayer service, was undertaken in orderly queues. Figures 19 and 20 are just some examples of this tendency. It is certainly possible that these photographs were posed, particularly since long rows of naked African children was a popular group pose for photographs of African children

¹⁵² Birmingham, CMS/G3/A7/ O, 1909 #309, quoted in G.B. Kyomuhendo and M.K. McIntosh, *Women, Work and Domestic Virtue in Uganda* (Oxford, 2006), 55.

¹⁵³ Leprosy Mission, 119/4, Dedication of the Chapel at the Leper Children’s Home, 1935.

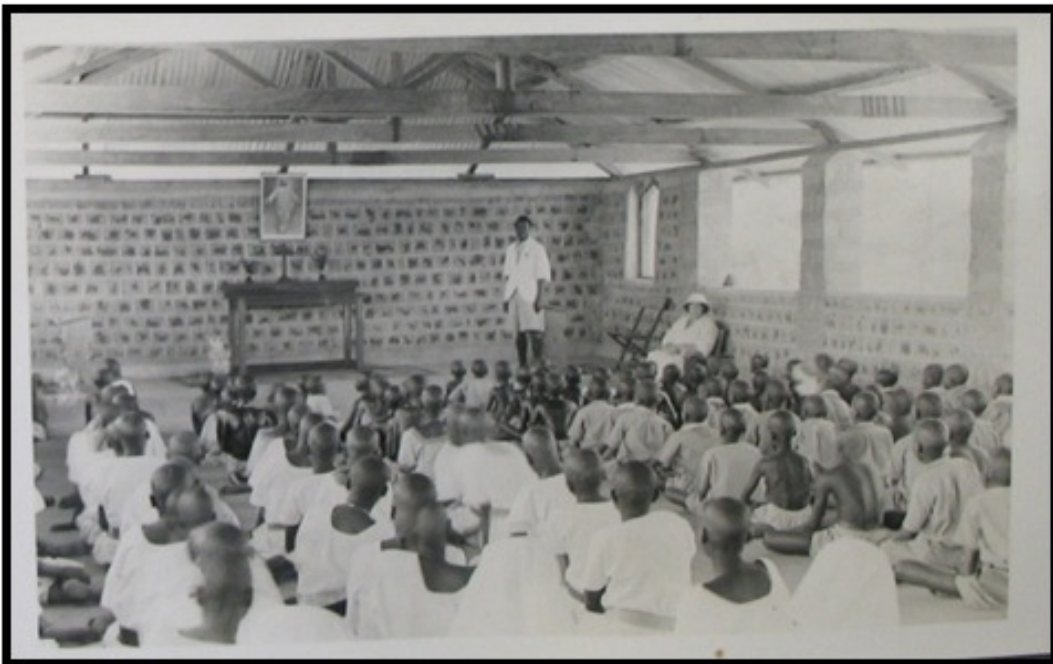


Figure 19: Top: 'Gathering for Service'; Bottom: 'Church Service at Kumi', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing.



Figure 20: 'Going for water for baths before school', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing

in the early twentieth century.¹⁵⁴ However, a large proportion of the photographs depict the children going through a regular motion, whether gathering to enter a daily prayer service (Figure 19), processing out of their dormitories in the morning to collect water for baths (Figure 20), waiting for medical treatment, or getting food. Even dressings were given in rows (Figure 21). Combined with written records of 'orderly rows', and further evidence of controlling tendencies on the part of the lady missionaries Laing and Kent, these photographs suggest that the missionaries at least endeavoured to maintain a regimented and controlled lifestyle for the children of the leprosy settlement.

Analysis of mission correspondence and publications provides further examples of ways in which the lady missionaries of Kumi attempted to impose conformity and regimentation onto their child leprosy patients. One common means of imposing discipline, conformity, and deference to the value of labour in children's institutions was the creation of a rigid daily timetable, which set aside an exact number of minutes or hours for all activities including bathing, schooling, and recreation.¹⁵⁵ Another means of inculcating conformity and a deference to civilisation was the provision of uniforms. Although the Kumi missionaries

¹⁵⁴ J. Beinart, 'Darkly through a Lens', 222.

¹⁵⁵ Murdoch, *Imagined Orphans*, 121-2; Dirks, 'For the Youth', 233.



Figure 21: 'Dressings at Kumi', Birmingham, CMS/ACC/356/Z2, Photograph Album of Miss Laing.

were ultimately unable to clothe all of their child patients in matching uniforms, due to a lack of resources, they did endeavour to dress all of the children similarly, and a set of clothes was given to all new in-patients. The missionaries did go to great pains to ensure that all of their Scouts, Guides, Cubs, and Brownies wore the appropriate uniforms of each movement, even though it meant turning away many students who wished to join Scouting or Guiding, because the mission could not afford enough uniforms.¹⁵⁶ Scout uniforms were perceived as a sign of trustworthiness around the world, and at Kumi Scouts and Guides were well-praised for their dependability.¹⁵⁷ But for the missionaries, uniforms were as much about promoting conformity and obedience as demonstrating the positive inner characteristics of children. In wearing their uniforms, the children felt great pride in being a part of a global movement; uniforms were a visible reminder that they belonged, whatever their status as Ugandan

¹⁵⁶ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1943.

¹⁵⁷ P. Fussell, *Uniforms: Why we are what we Wear* (Boston, 2002), 3.

leprosy patients, to another community, and in order to earn that membership they needed to behave with respect, discipline, and service towards others.¹⁵⁸

Leaving the Mission's Alternate World

Although one of the primary goals of the Kumi Children's Home was meant to be the 'cure' and release of child leprosy patients, who could then go on to spread civilisation and Christianity in their home community, on many occasions Miss Laing did her utmost to prevent children from leaving the settlement, even if they showed no further symptoms of leprosy. Laing worried that if children returned to their parents, the physical and moral progress that they had made inside the settlement would reverse. After all, 'It would be a pity for these young folk...who show such promise, and who have been disciplined and taught to live in clean and healthy surroundings, to drift back to their old and undesirable customs'.¹⁵⁹ The missionaries hoped that their engendering of a 'mental and moral uplift will endure the return to native home life for these boys and girls', but in many cases, Miss Laing at least seems to have been pessimistic about the reality of these hopes. She frequently wrote such statements as: 'We must think and pray a lot for these children...It is really very hard for them to live true Christian lives in their villages'.¹⁶⁰ In order to avoid this lapse of civilisation, Miss Laing forwarded the idea of creating a hostel and technical school where symptom-free children 'could be under supervision for a considerable length of time after leaving the Leper Home'.¹⁶¹ No funders were enthusiastic enough about this idea to see it fulfilled, but there were instances when symptom-free youths would stay on at the settlement in order to train as leprosy assistants, or be sponsored by the mission to study nursing, teaching, or other professions, so that they might eventually return to Kumi to work.

¹⁵⁸ Parsons, *Race, Resistance, and the Boy Scout Movement*, 31.

¹⁵⁹ RCA, Kumi Annual Report, 1947.

¹⁶⁰ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report, 1941.

¹⁶¹ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

A far greater problem for the mission than the lapse of civilisation was the departure of child leprosy patients whose treatment was not yet complete. There were many instances of children ‘absconding’, and even more frequently, of parents withdrawing their children from the settlement while they were still suffering from symptoms of leprosy. While the colonial government would not allow compulsion to be used in bringing these children back to the settlement, when requested, the District Commissioner (DC) would send a letter to a local chief, inquiring as to a child’s whereabouts and encouraging him to apply ‘moral persuasion’ to convince parents to send their child back to the settlement.¹⁶² Indeed, the Teso DC’s archive contains dozens of letters written between the Kumi missionaries and the DC, and the DC and local chiefs, wherein they tried to trace the child patient, and then report on the child’s condition:

Certainly no one is ever compelled to come here for treatment, but this girl was brought willingly by her people and we do expect them to be left with us until pronounced symptom free. These people deliberately took the child away although they had been told that they would be in-formed as soon as she was ready for discharge, and now she will spread infection and become worse herself, as well as losing the benefit of the treatment she has received. Not only this but we have had several people from this district doing the same thing and I was anxious if possible to make an example of this case. I am sure you will understand that it would be a very serious thing for the discipline of this place if patients were allowed to do this sort of thing.¹⁶³

If the lady missionaries did not receive an adequate reply, they would write back to the DC every few months until they heard of the child’s whereabouts. Or, if a family member of the child lived nearby, they would send an *askari* (policeman) to find them.¹⁶⁴ Once a child was located, the DC or missionaries often tried to induce the parents to return their child by requiring the payment of the child’s school fees for the duration of their time in the settlement.¹⁶⁵ Under normal circumstances, parents were not asked to contribute financially to a child’s upkeep while living in the settlement, but the missionaries would use any means

¹⁶² SDA, X/NAF/9, Letter from DC Teso to M. Laing, 28 April 1945.

¹⁶³ SDA, X/NAF/9, Letter from A. Kent to DC Teso, 4 June 1946.

¹⁶⁴ SDA, X/NAF/9, Letter from DC Teso to M. Laing, 12 December 1944.

¹⁶⁵ SDA, X/NAF/9, Letter from DC Teso to M. Laing, 28 April 1945.

of persuasion or inducement to hold on to children, as long as the colonial government did not forbid it as compulsion.

Given that the release of child leprosy patients was inevitable in many cases, Miss Laing made an effort to establish “After Care Committees” to follow up with young, discharged patients and offer them some support and supervision.¹⁶⁶ While she was unable to establish the network that she envisioned, she was able to use mission resources to set up an informal network that connected these former patients to the Anglican Church of Uganda. The Kumi missionaries would notify the local Ugandan pastor of the names of discharged patients in their districts, and these pastors would in turn keep an eye out for these youths, and inform the missionaries of their ‘progress’, and whether or not they had been attending masses.¹⁶⁷ Miss Laing also got word of former patients through other discharged patients who lived locally, through CMS missionaries stationed nearby, through local Chiefs and schoolmasters, and on her own medical safaris. While she undertook these safaris to identify new cases of leprosy, in later years she also used these journeys to meet up with former patients, some of who had gone on to marry and were still leading Christian lives. As she wrote, ‘It was good also to know that the early teaching in this Home, of the Knowledge and Love of Jesus was showing results’.¹⁶⁸ Through whatever means available to them, the lady missionaries attempted to keep the network, or family, of the Kumi Children’s Leper Home intact, even as symptom-free patients returned to their homes across northern and eastern Uganda.

The Child Leprosy Patients and their Families

During their time at Kumi, the lady missionaries Laing and Kent endeavoured to separate child leprosy patients from their families, cast them as orphans, and create a new

¹⁶⁶ RCA, Kumi Annual Report, 1947.

¹⁶⁷ Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

¹⁶⁸ Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

family for them. As discussed by historian Lydia Murdoch, the tradition of children's welfare institutions recasting children as orphans grew in the nineteenth century, as British reformers increasingly blamed parents for the plight of their innocent children. These reformers cast poor parents as villainous, and they attempted to separate their children from them, severing all connections to their past, portraying them as orphans and embarking within children's institutions on a welfare programme intended to reclaim them as citizens, without external interference and damage. If parents were mentioned at all in philanthropic narratives of childhood welfare reform, it was as dangerous abusers. The mission's narratives about Kumi echo these nineteenth-century narratives, from the aspersions they cast on the children's families, to their attempts at replacing the children's families with a new, CMS Kumi family. The 'untainted' children of leprosy patients were especially likely to be cast as orphans, for though they were 'not without parents, but whose parents being Lepers, can have no care of them'.¹⁶⁹ However, children and their families had a very different idea of the value of Kumi as a children's institution, and they often negotiated within the mission's system in order to derive the most benefit for themselves.¹⁷⁰

The Mission and Family Negotiate

In admitting a child as an in-patient, the mission was physically distancing children from their parents, and whilst the children were with them, they hoped to distance their social and emotional ties to their biological family as well. However, a child's entry into the leprosy settlement was ultimately a family decision, not a mission decision, as was the decision to allow a child to stay until their treatment was completed. In the first instance, the missionaries had therefore to negotiate with the families and children in order to make entry into the settlement an attractive option.

¹⁶⁹ Leprosy Mission, 119/5, Gertrude Hopkins, 'Leper work at Kumi and Ongino', 1945.

¹⁷⁰ Murdoch, *Imagined Orphans*, 1-7.

Most of Kumi's patients were admitted because their local chief 'made an effort to tackle the Leprosy question...seriously' or because Miss Laing had examined them on a medical safari, labelled them as leprosy, and attempted to persuade their parents to send them to the settlement.¹⁷¹ While chiefs may well have used political or social pressure to compel parents to send their children to Kumi, it is unlikely that stigma played a role in a family's decision to send a child to the settlement. Before the 1930s, the Iteso did not recognise leprosy as a distinct disease, but rather as a variety of different ailments, depending upon its symptoms. The majority of parents were therefore probably not sending their children to Kumi for treatment because they believed the missionaries could offer a biomedical cure for the disease, and in fact Ugandan chiefs advised Dr. Wiggins that he would get far more in-patients if he attached a school to the settlement.¹⁷² Missionaries wrote that 'parents are gaining confidence in us' and 'beginning to realize how beneficial it is to their leprosy children, to let them come to us and remain under proper treatment'.¹⁷³ Undoubtedly these missionaries believed that these parents were coming to recognise the value of biomedicine, but given the proportion of children who stayed in the settlement in order to procure technical training or sponsorship for another mission training school, it is not hard to imagine that the free educational opportunities at Kumi were more of an inducement than biomedicine. Dr. Wiggins did write that Kumi was 'seen as a Boarding school more than a Hospital'.¹⁷⁴

The missionaries of Kumi hoped that once children had been admitted into the settlement, they would be able to distance them from their families and create a new family and community for them within the mission. Family was considered as the ultimate moralising agent, and from the founding of the French juvenile reformatory of Mettray in

¹⁷¹ Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 8 January 1929; RCA, Kumi Annual Report, 1947.

¹⁷² Leprosy Mission, 118/16, Ngora Leper Mission Annual Report 1928.

¹⁷³ Leprosy Mission, 119/4, Letter from M. Laing, 12 March 1934; Birmingham, CMS/G3/AL Marjorie Atkinson 1930.

¹⁷⁴ Birmingham, CMS/G3/AL C.A. Wiggins 1930.

1840, many children's institutions sought to reform children by recreating a domestic environment.¹⁷⁵ Moreover, in some juvenile reformatories, community was considered as the most powerful force for discipline, and in the context of regenerating childhood innocence, community was most effectively constituted through the creation of a large family.¹⁷⁶ Visitors wrote of Kumi as a big family and a home, with the lady missionaries as mothers, Ugandan staff as fathers, and the leprosy patients as their children. Miss Laing 'has indeed been a Mother to these people as they have affectionately called her, and it is a home in every sense of the word'.¹⁷⁷ A few years earlier, a visiting Briton wrote admiringly:

There one saw continually demonstrated high efficiency and marvellous discipline, softened by complete devotion into the happy, fearless atmosphere of a real home. A huge home of helpless children entirely dependent upon the care and counsel of these two women, yet everywhere a freedom of spirit and an eagerness to be helpful; everyone conscious of being part of a whole; each member of the community contributing in small or large degree to the welfare of the whole. A truly happy family, though its numbers are so great.¹⁷⁸

The missionaries saw themselves and select Ugandan staff members as parental figures, and they reported incidents that validated this perception, such as when one boy asked to be baptised Onesimus, so he could be called after the head Ugandan staffer of Kumi.¹⁷⁹ In another instance they wrote that 'Onesimus...has indeed been a real Father to all these children. Semu was mostly cared for by Onesimus, during his childhood, and so he takes a great pride in him. Semu is a Leader, and in many ways follows Onesimus's example'.¹⁸⁰ Sicola, the only former Kumi leprosy patient interviewed, also recalled Laing as being like a mother to her.¹⁸¹

Despite the wishes of the lady missionaries, the relationships between children and their parents were not so easily severed, and even those children who spent their lives living

¹⁷⁵ Driver, 'Discipline without Frontiers?', 273-7.

¹⁷⁶ Chisolm, 'Education, Punishment and the Contradiction of Penal Reform', 31.

¹⁷⁷ Leprosy Mission, 119/5, Letter from A. Kent, 12 July 1948.

¹⁷⁸ Hopkins, 'A Kenya Picture', 26-7.

¹⁷⁹ Laing, 'Children's Leper Home', 244.

¹⁸⁰ Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

¹⁸¹ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

at Kumi and then Ongino still managed to maintain connections with their families. In the 1930s, necessity prompted unhappy missionaries to allow parents to collect their children for an annual one-month visit at home, though as children were admitted from increasingly distant locations, these annual holidays decreased in proportion.¹⁸² Parents were also permitted to visit their children for several days at a time, and when children were severely ill or missed their parents very much, the missionaries would send word for parents to come and see their child. One child, when asked on his deathbed what he would like most, said ‘Sister I want to go home, just go home and see my people’.¹⁸³ Ultimately, however many years a child spent at Kumi leprosy settlement, and whatever the pain of separation they may have felt or the changes they might have undergone, more than 90 percent of them eventually returned home to their families. Most of those who stayed on at Kumi or Ongino also maintained relationships with their families; when two leprosy patients wanted to get married, for example, the missionaries sent word to their families, asking for the father of the bride’s permission, or for a representative of the family to be present, as was local custom.¹⁸⁴

Theoretically, parents were also allowed to withdraw their children from the settlement whenever they chose, but in some instances Miss Laing acted as an obstruction between child patients and their families, endeavouring to keep the children within the settlement. In August of 1947, Miss Laing wrote to the Teso DC, asking him to send a letter to the chief of Toroma to the effect that a young patient, Paulo, was healed of leprosy, and his parents should come and retrieve him.¹⁸⁵ The letter was sent, and the boy’s father travelled to Kumi to pick his son up. Three weeks later, the chief of Toroma wrote back to the DC to inform him that the father went to collect Paulo, but Miss Laing refused to release him until

¹⁸² Leprosy Mission, 118/16, Letter from Wiggins to Anderson, Secretary, Mission to Lepers, 17 November 1931.

¹⁸³ Leprosy Mission, 119/5, Gertrude Hopkins, ‘Leper work at Kumi and Ongino’, 1945.

¹⁸⁴ SDA, X/NAF/9, Letter from Kent to DC Teso, 14 October 1946.

¹⁸⁵ SDA, X/NAF/9, Letter from Laing to DC Teso, 14 August 1947.

his father had paid all of his primary education expenses.¹⁸⁶ When the DC wrote back to Miss Laing to inquire, she told him: ‘the Boy Paulo cried so bitterly at the thought of going back to Toroma, that I have had to keep him a little longer. He is now 12 years old and if I can find the money I will help him to go to school’.¹⁸⁷ According to Miss Laing, she stood between Paulo and his father at Paulo’s request, and to do this she used money, asking the father to hand over a sum of money that he would not be able to immediately afford in order to buy herself some time before he was able either to raise the money or go through his chief and the DC in order to force Miss Laing to release his son. This was not the only instance in which Miss Laing used money as a negotiating tactic with the relatives of leprosy patients, particularly when it came to the question of compelling parents to leave their child in the leprosy settlement.

Negotiations over bridewealth were another significant cause of tension between Miss Laing and the relatives of leprosy patients. One former child leprosy patient, Sicola, who came to Kumi as one of the earliest child leprosy patients, in 1931, spoke of the damage Laing did to her relationship with her family. When she married another leprosy patient, he paid a bridewealth of cows for her. But when her father came to collect these cows, as was his due as a male relative, Miss Laing refused to give the cows to him, claiming that she had gone to all of the expense of raising and educating Sicola, and therefore the bridewealth rightfully belonged to her. Forever after, Sicola’s family would not have anything to do with her; cattle were the basis of kin relations in Teso, and if Sicola’s family did not receive her bridewealth, then she was not their family.¹⁸⁸ It may be that Laing was unaware of the damage that would result from her behaviour, but as a mother to all of the children at Kumi, she felt it her right to intervene in their family affairs.

¹⁸⁶ SDA, X/NAF/9, Letter from Chief Toroma Parish to DC Teso, 8 September 1947.

¹⁸⁷ SDA, X/NAF/9, Letter from Laing to DC Teso, 15 September 1947.

¹⁸⁸ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9); J. Vincent, *Teso in Transformation* (Berkeley, 1982), 67.

Overall, it is difficult to know why Miss Laing chose to intervene in the relationships of some leprosy patients and not others. For all her efforts to keep child leprosy patients at Kumi, or to keep them away from their families by sponsoring them to attend another mission school, there were many children that she personally escorted back to their families, on her medical safaris.¹⁸⁹ The previous two examples suggest that she would intervene on behalf of children who did not wish to return to their families, or with young men and women who had lived in the settlement for many years, and to whom she felt a particular familial connection or responsibility.

The Perspectives of Kumi's Child Leprosy Patients

Uncovering the perspectives of Kumi's child leprosy patients is a challenging prospect, as they have left no available written records, and I have been able to conduct only one interview with a former child patient, who is now in her nineties. If the CMS missionaries who ran the Kumi Children's Leper Home are to be believed, almost all child leprosy patients were passive vessels for the civilising graces that the mission offered. However, reading between the lines of the extensive missionary accounts of these children, it is evident that, on the contrary, the children were very capable of adapting to the mission's new structure of authority, and negotiating within that structure to pursue the outcomes that they perceived as beneficial to themselves.

The strongest statement of dissatisfaction that a child could make about their life at Kumi was simply to leave.¹⁹⁰ Runaway children were always a problem for Kumi's missionaries; in 1948, one in 50 child patients 'absconded'. The fact that one in three adult patients absconded from nearby Ongino in the same year suggests that running away was a far more difficult prospect for children than adults.¹⁹¹ Children who were distanced from

¹⁸⁹ SDA, X/NAF/9, Letter from DC Teso to Chief Amuria District, 13 June 1947.

¹⁹⁰ Murdoch, *Imagined Orphans*, 99.

¹⁹¹ RCA, Kumi Annual Report, 1948.

their adult care networks were especially vulnerable, and such a child was far less likely to find the wherewithal to travel great distances on their own, though it is worth noting that children tended to run away in groups.¹⁹² The proportion of child runaways was certainly higher in the 1930s, when most of the settlement's patients came from Teso, as opposed to the late 1940s, when only 39 percent of the settlement was Iteso.¹⁹³

Though some children were not able to run away from Kumi, they still had a variety of ways in which they could protest their unhappiness. Some possible causes of unhappiness recorded by the missionaries were children missing their families, disliking school and the enforced routine that they had to live under, disliking the painful injections they received as medical treatment, and being forced to eat eggs, which were culturally taboo for women.¹⁹⁴ The missionaries and staff of Kumi could not force children to conform to the standards of behaviour that they expected, and there are a very few instances where missionaries recorded bad behaviour among the child patients. Miss Laing wrote that:

We have a good deal of trouble with some of the children. There is a great deal of lying and stealing...Most of these things are done through ignorance and the lack of knowing how to control themselves. After all we are here to teach them...to follow [Christ's] example of Obedience, Gentleness, Love and Service. I know that many of our little leper friends are understanding better, and that they are really trying to serve Jesus in the Home. It is a joy to see some of the changes in the older children.¹⁹⁵

The lady missionaries equated bad behaviour with a lack of understanding, but it is far more likely that these children behaved badly because they were unhappy or resentful. After all, why should they follow Christ's standards of obedience, gentleness, love, and service? CMS nurse Ailsa Pank later wrote that:

The children are very difficult to teach, as many have never been to school before coming here, and resent having to do so now. This is evidenced by perpetual efforts to hide behind buildings and in the bush whenever possible during school hours, and to evade both school and outdoor work to the utmost extent.¹⁹⁶

¹⁹² Lord, 'Child Labor in the Gold Coast', 100; SDA, X/NAF/9, Letter from DC Teso to A. Kent, 15 May 1946.

¹⁹³ Birmingham, CMS/G3/AL Ruby Robinson 1930.

¹⁹⁴ SDA, X/NAF/9, Letter from Chief Otuboi Parish to DC Teso, 26 April 1946.

¹⁹⁵ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

¹⁹⁶ Birmingham, CMS/G3/AL Ailsa Pank 1951.

Obviously not all of the children at Kumi were as ideally happy as the missionaries liked to pretend, and they had ‘infinite scope’ for evading authority within the confines of the leprosy settlement. Children were also able to adapt the missionaries’ discourses to their advantage in offering excuses for their continued behaviour, for example the frequent explanation: ‘Satan did enter my heart and take hold of me, and I am sorry’.¹⁹⁷

While some children were unhappy living at Kumi, many more seem to have enjoyed their time at the settlement, particularly the ample opportunities for recreation and education. Learning to read, write, and sew reputedly caused great excitement among many children, as did visits from the cinema van, Christmas celebrations, and occasional treats like a South African air squadron doing a flyover for them.¹⁹⁸ Performing jobs that they had been specially trained for gave ‘an air of importance’ to some youths.¹⁹⁹ When told that they were ready to be released symptom-free, some children wept and asked if they could return to the settlement if they were unhappy at home.²⁰⁰ Doubtless some children did genuinely prefer life in the settlement, with its varied activities and entertainments, its schooling, medical care, and ever-present supply of food, clothing, and other material necessities. Some children may have wanted to stay in the settlement because of the economic opportunities and freedom they believed it would afford them. One missionary wrote of former Kumi patients who had returned to work, ‘To see these nurses now fully trained doing practical nursing in this Leper Hospital at present, is a great inducement to others, who are *nearly* well and *can* be trained in nursing and other subjects if they wish to do so’.²⁰¹

Anecdotal evidence from other leprosy settlements in Uganda suggests that Christianity may be one reason that some patients were reluctant to leave, as most came from

¹⁹⁷ Leprosy Mission, 119/4, Letter from M. Laing, April 1935.

¹⁹⁸ Birmingham, CMS/G3/AL Marjorie Atkinson 1931-32; Leprosy Mission, 119/4, Letter from M. Laing, December 1942.

¹⁹⁹ Kent, ‘Leper Children’s Home’, 163.

²⁰⁰ Leprosy Mission, 119/4, Letter from M. Laing, February 1938.

²⁰¹ Birmingham, CMS/G3/A10/m1A, Kumi Annual Report 1943.

areas where the religion had not yet become well established. In other colonial contexts, evidence suggests that children who converted to Christianity within children's institutions had a harder time reintegrating into their community when they returned home.²⁰² The missionaries did worry that children were too eager to convert, influenced by the evangelisation of their peers and not fully understanding the enormity of the decision to become Christian. The fact that, in the 1940s, almost all child leprosy patients who were discharged symptom-free had been baptised Christian, whereas no more half of the adults had converted, does lend some credence to the notion that child evangelisation was not necessarily as sincere as missionaries hoped.²⁰³ Oral interviews suggest even that some children felt they were coerced into conversion.²⁰⁴ Nevertheless, there were many children who were baptised and confirmed at Kumi, and went on to lead Christian lives for the next few years, at least.²⁰⁵

For parents, the choice to send their child away to receive education and biomedical care was one with costs and benefits. While parents did not have to pay their children's school fees, in parting from their child they were reducing their household labour supply, possibly for years.²⁰⁶ For the Iteso, children's labour had always been one of the primary means of accumulating wealth.²⁰⁷ Given the demands that the colonial cotton economy placed on the labour of adult males in Teso, in the colonial period children's labour became increasingly important for the household economy. As most of the children in the leprosy settlement were of an age to contribute productively to that household economy, sending them away to the leprosy settlement was a sacrifice.

²⁰² Dirks, 'For the Youth', 310.

²⁰³ All children discharged in this one year were Christian.

²⁰⁴ Interview with Sicola, 7 July 2010 (Kumi).

²⁰⁵ Leprosy Mission, 119/4, Letter from M. Laing, 9 March 1940.

²⁰⁶ Lord, 'Child Labor in the Gold Coast', 90-3.

²⁰⁷ Vincent, *Teso in Transformation*, 68.

For children willing to make certain sacrifices, however, admission to Kumi could be means of gaining agency and some freedom from their family's household economy.²⁰⁸ One of these costs was living apart from family, which was an especial strain for those children whose parents could not afford the expense of travelling to visit them regularly. Another cost was the necessity of following the lifestyle and mould of behaviour set out by the mission. If a child did not embody the characteristics that the missionaries saw as the remit of a civilised, Christian Ugandan, then they would not be given the opportunity to extend their education, whether it was technical education such as carpentry or masonry, or a more literary education such as teaching or nursing. However, if a child was willing to endure a separation from their family and to follow the behavioural mould proscribed for them, they were given the option of learning skills that would enable them to pursue a livelihood more profitable than their parents could probably have arranged for them, given the poverty of the households from which most child leprosy patients came.²⁰⁹

The range of training available at Kumi was limited to those pursuits that the mission deemed appropriate for Ugandans and useful for the maintenance of the settlement, for instance tailoring, carpentry, plastering, cement work, stone masonry, painting, cooking, nursing, teaching, and midwifery.²¹⁰ However, the basic education provided during several years at Kumi was translatable to the rural schooling system in northern Uganda, and about a third of discharged child patients were able to continue attending school, with the financial support of their families or the mission. Skills that they learned at Kumi could also act as a supplement to their agricultural income in future years; while the mission's emphasis on teaching handwork was more about defining gender roles and promoting the values of industriousness, such training could offer extra economic opportunities. The mission's emphasis on technical education, rather than literary education, can be seen as an expression

²⁰⁸ Vincent, *Teso in Transformation*, 230; Ocobock, 'Coming of Age in a Colony', 159-60.

²⁰⁹ Ocobock, 'Coming of Age in a Colony', 169-70.

²¹⁰ M. Laing, 'Ng'ora Leper Mission', *Mission Hospital*, 40.463 (August 1936), 188.

of derogatory beliefs about the intellectual abilities of Ugandans and their place in the British Empire, but practically speaking, a literary education did not always translate to later economic benefits for children.²¹¹ Ultimately, therefore, whatever the educational opportunities offered to a child leprosy patient at Kumi, there was some possibility of future economic benefit. This was, after all, an explicit intention of most children's institutions, across the globe.²¹²

With many opportunities at their fingertips, children were sometimes at odds with their family over how their futures should proceed.²¹³ Yet although the more extensive educational opportunities provided at Kumi offered youths the opportunity to mould their own futures, distance from family does not seem to have been a motivation for living at Kumi. If the former child leprosy patients who staffed Kumi and Ongino as adults are any indication, distance from relatives did not mean dissociation. After experiencing conflict with Ugandan staff members, Dr. Wheate wrote that Europeans were 'apt to criticise the African for lacking social sense and almost invariably subordinating work to the incessant demands of his enormous family circle, every member of whom, however remotely related, appears to have some claim on him'.²¹⁴ However many years they lived separate from their relatives, a child's relationship with his or her family tended to endure.

Conclusion

The salvation of the poor, savage child was a popular theme in British philanthropy in the nineteenth and twentieth centuries, and as colonialism expanded, so too did the remit of the philanthropist, from the troubled 'street Arab' of Britain to the suffering children of Africa. The Kumi Children's Leper Home, highly praised as it was by humanitarians and leprologists, was one expression of this empire-wide desire to create institutions in which

²¹¹ Lord, 'Child Labor in the Gold Coast', 95.

²¹² Dirks, 'For the Youth', 258-9.

²¹³ Grier, *Invisible Hands*, 164.

²¹⁴ Birmingham, CMS/G3/AL Ailsa Pank 1951.

children could be reclaimed for the British Empire by indoctrinating them into an alternate world of civilisation and subordination.²¹⁵ As an in-patient children's institution, Kumi offered CMS missionaries the opportunity to mould children into their vision of a healthy, civilised, and Christian Ugandan adult, away from the influence of these children's adult relatives. In saving these children from disease, dangerous parents, and a 'primitive' lifestyle, these missionaries believed that they were offering child leprosy patients a future, and hoped that in turn these children would use that future to spread the values of civilisation to their communities upon release from the settlement. With the healthcare and education offered at Kumi, the missionaries were indeed offering child leprosy patients a different future than they might otherwise have had. However, children and their families did not always share the mission's perception of the value of biomedicine, civilised British characteristics, and Christianity, or the mission's vision for the ways in which the lessons learned at Kumi should influence children's futures. Ultimately, it was the choice of children and their families whether to enter the leprosy settlement, how to behave while living there, and what to gain from the experience.

²¹⁵ Murdoch, *Imagined Orphans*, 1-42.

Chapter 5: Pursuing Wealth and Health: The Role of Families, Local Communities, and Leprosy Patients in Settlement Entry and Life

Leprosy settlements have a popular reputation as total institutions where leprosy sufferers are compulsorily incarcerated and segregated from the rest of the world until their cure or death.¹ However in colonial Uganda, as in most of Africa, leprosy settlements were not prisons, but rather fluid spaces which involved leprosy patients, their families, and members of the outside community.

This chapter opens with a discussion of who the residents of Uganda's leprosy settlements were and how and why they came to enter the settlements. While the missionaries believed that patients entered the settlement voluntarily in pursuit of their future health, in actuality leprosy sufferers, their family members, or local chiefs made the decision of a patient's entry, sometimes for medical reasons, but also in the furtherance of economic, political, and social goals. Nor did patients live in isolation once they had entered the settlement, and this chapter discusses the extent of contact between leprosy patients and 'untainted' families and neighbours, concluding with an examination of the relationship between the leprosy settlements and neighbouring communities.

Drawing on mission and government records and interviews with former leprosy patients at Kumi, Nyenga, and Buluba, this chapter demonstrates the extent to which entry into and life within Uganda's leprosy settlements was collaborative, rather than a binary endeavour in which missionaries and leprosy patients stood in total opposition and isolation.²

The Residents of Uganda's Leprosy Settlements

This section outlines the quantity, age, gender, ethnicity, and family situation of the residents in Uganda's leprosy settlements. As Figure 4 (see page 55) demonstrates, the number of patients in each of Uganda's leprosy settlements fluctuated annually. At Buluba

¹ Edmond, *Leprosy and Empire* (New York, 2006), 143.

² In the footnotes Chapters 5 and 6, the name of the interviewee and the date of the interview are followed by the leprosy settlement that they entered, the year of entry, and their age upon entry.

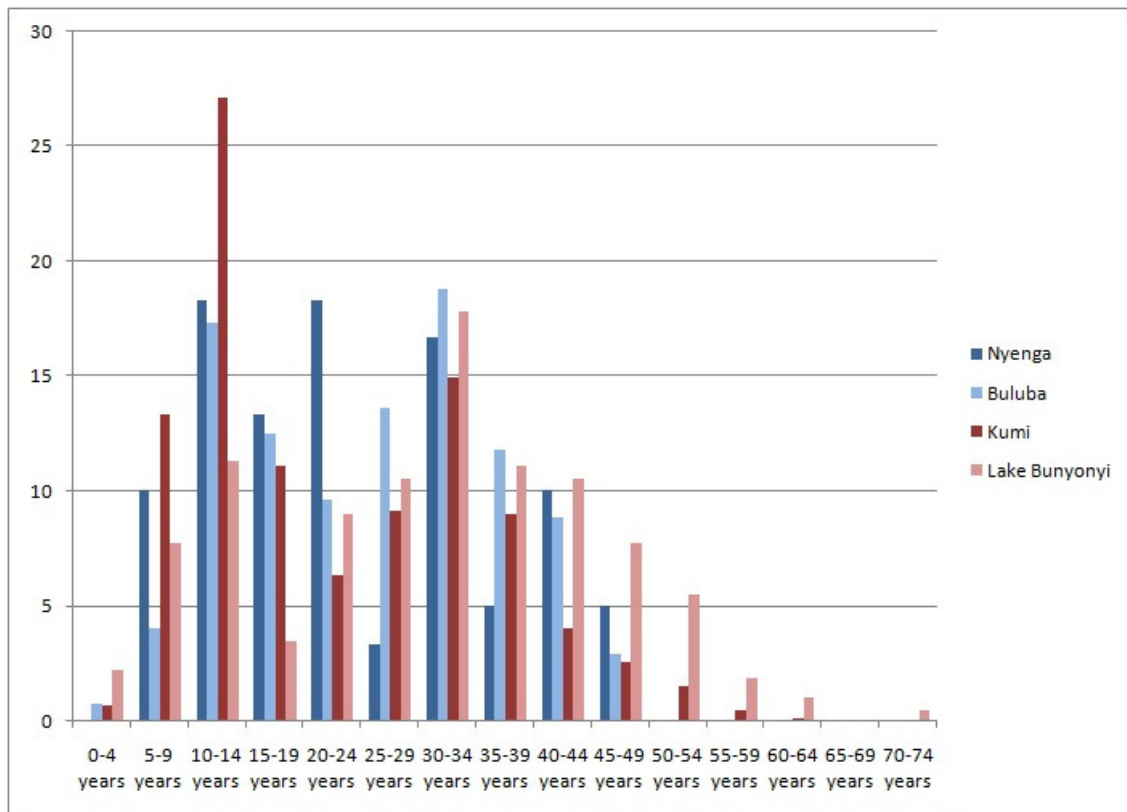


Figure 22: Percentage of patients within each age group at Uganda's leprosy settlements, 1947.

and Nyenga, the number of in-patients was generally between 150 and 250, at Kumi and Ongino between 600 and 1100, and at Lake Bunyonyi, between 600 and 900. According to Dr. Innes' 1947 survey of leprosy in Uganda, patients of all ages came to each settlement (see Figure 22). Kumi had an especially large percentage of children, as one half of the whole was devoted to children only. Both CMS leprosy settlements admitted more elderly patients, up to the age of 75, than did the FMSA settlements, where more than 95 percent of the patients were between the ages of five and 50. There were usually more men than women in the settlements, often at a ratio of about three men for every two women. At Buluba, approximately one-third of these women were married and cohabiting with their spouses within the settlement, and at Lake Bunyonyi, two-thirds. Each settlement also housed a number of 'untainted' relatives of leprosy patients, including spouses and children. In 1948, there were 32 men, 99 women, and 141 children, totalling 302 non-patients, as compared to

528 leprosy patients living at Kumi.³ There were no non-patients living at Nyenga, and there were eight non-patients and 270 patients at Buluba.⁴ In 1949, there were 170 non-patients and 757 patients resident at Lake Bunyonyi, the vast majority of non-patients being children.⁵ In the 1930s, there had been much higher numbers of ‘untainted’ adults living at the Bunyonyi settlement, with their leprosy patient spouses, but as space on the island became increasingly limited, missionaries began turning away ‘untainted’ relatives.

In the 1930s, the vast majority of the leprosy patients at each settlement came from the ethnic group that predominated in the area surrounding the settlement. This was the Iteso at Kumi, the Bakiga at Lake Bunyonyi, the Baganda at Nyenga, and the Basoga at Buluba. In the 1940s, as the majority of nearby sufferers were being treated, and as word of each settlement spread across the country, leprosy patients began travelling from greater distances to enter the settlements. In 1941, the predominant ethnic groups at Kumi were Iteso (69 percent), Bagwere (14 percent), Bagishu (8 percent), and Acholi (4 percent).⁶ In 1949, the ethnic composition of the settlement had shifted greatly, to Teso (39 percent), Bagishu (25 percent), Lango (11 percent), Acholi (8 percent), and 17 other ethnic groups (17 percent).⁷

From the outset, the ethnic composition of the patients at Lake Bunyonyi was more varied. The majority of the settlement’s patients were Bakiga, but with the settlement located only 30 kilometres from the Rwandan border, a large minority of the settlement’s residents were Banyaruanda. In 1932, for example, Banyaruanda accounted for a quarter of the settlement’s population.⁸ In 1950, the predominant ethnic groups at Lake Bunyonyi were Bakiga (53 percent), Banyaruanda (28 percent), and Bahororo (18 percent).⁹

³ RCA, Kumi Annual Report, 1948.

⁴ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3.

⁵ RCA, Lake Bunyonyi Annual Report, 1949.

⁶ SDA, X/NAF/9, Breakdown of Patient Ethnicity, sent to DC Teso, May 1941.

⁷ RCA, Kumi Annual Report, 1949.

⁸ R. Langley, ‘News of the Lepers’, *Ruanda Notes*, 41 (July 1932), 17.

⁹ J.R. Innes, ‘Leprosy in Uganda, A Survey in the Kigezi District’, *East African Medical Journal*, 27.7 (July 1950), 281.

When Nyenga opened in 1932, the vast majority of the patients were Baganda, and the minority came from neighbouring Busoga. In the 1940s, however, only 36 percent of Nyenga's new in-patients were Baganda. The other two predominant ethnic groups were Mukavirondo (13 percent) and Mudama (9 percent), and the remainder of new additions came from across Uganda and Rwanda.¹⁰

Buluba was unusual amongst all of the leprosy settlements in that, throughout the 1930s and 1940s, a majority of its in-patients remained Basoga. In 1945, 71 percent of Buluba's in-patients were Basoga, five percent were Baganda, four percent were Iteso, with the remaining patients hailing from across Uganda, the Sudan, Congo, and Rwanda.¹¹ At both Nyenga and Buluba, many of the patients who came from particularly long distances had been working in nearby sugar plantations when the symptoms of leprosy manifested.

Entering a Leprosy Settlement by Persuasion or Compulsion

Theoretically, entrance into one of Uganda's mission leprosy settlements was entirely voluntary, and as such, one of the most enduringly important tasks of the missionaries was locating leprosy patients, making sure they were informed of the settlement's existence and purpose, and then encouraging them to enter the settlement. As the settlements grew in local renown, word of mouth became an increasingly important factor in bringing in new leprosy patients. Far more important, however, were the 'medical safaris' that missionaries undertook in order to identify leprosy cases and convince potential patients to leave for the settlement, and the role of Ugandan chiefs who, in concert with district administrators, often identified and pressured leprosy sufferers to enter a settlement.

The majority of in-patient admissions at the two CMS leprosy settlements resulted from medical safaris undertaken by CMS nurses or doctors. These trips would often last several weeks, especially when they were taken into more remote areas where motor travel

¹⁰ Nyenga Hospital, Patient Register, 1945-51.

¹¹ JDA, Medical Leprosy, Letter from Sr. Felicity to DC Busoga, 1 September 1945.

was not possible. Local chiefs or village headmen were informed of the missionary's projected arrival, either by the missionaries themselves or by the District Commissioner (DC). In Kigezi, Dr. Sharp frequently asked the chiefs to gather the whole village together, and he would preach, provide basic medical care for those who requested in, and while doing so examine people for signs of leprosy. Once he located a leprosy patient, Sharp took them aside and talked to them 'in their own language about the Island and what the advantages are and what it means to them and the future generation'.¹² According to his daughter, who accompanied him on most of these safaris, he told them:

They would have some place to live, they would have clothes, they would be treated and helped, and they'd have some medical treatment, their sores would be dressed. If they're fit enough, they'd have some land which they could cultivate. They could bring their family if they needed to; there was a chance of a new life.¹³

He also brought Ugandan staff from the settlement with him, to talk to leprosy sufferers about their experiences at Bwama.

In later years, Sharp often specifically asked chiefs to gather any known leprosy sufferers for his visit, along with a list of local arrested leprosy patients, who had been discharged but needed to be examined regularly for signs of leprosy's reoccurrence. Nurse Laing, who was responsible for most medical safaris from Kumi, also wrote ahead to ask chiefs to gather together anyone whose symptoms could indicate the presence of leprosy. As visiting leprologist Dr. Muir observed, 'The way in which patients are recruited is particularly interesting. The Chiefs are occasionally asked by the DC to call lepers together to headquarters where they are addressed by Miss Laing, recovered lepers being demonstrated to show the effects of treatment'.¹⁴ In addition, Miss Laing visited many schools to search for children in the early stages of leprosy, who displayed very little outward

¹² R.R. Webster, 'At the Home Base', *Ruanda Notes*, 46 (1933), 5-6.

¹³ Interview with Joy Gowers, 12 February 2010.

¹⁴ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

evidence of the disease.¹⁵ Of course, the success of these medical safaris relied heavily upon the cooperation of local chiefs, and while some gave ‘willing and intelligent co-operation’, others were ‘inefficient’ and took little trouble in locating or compelling leprosy sufferers to attend for mission inspection.¹⁶

Although the travelling missionaries usually located several dozen leprosy sufferers on each safari, it did not necessarily follow that these men, women, and children would choose to return with the missionaries to enter the leprosy settlement. On his medical safaris in Kigezi, Dr. Sharp offered potential leprosy patients the opportunity to travel directly to the settlement with him, but few took up this offer. Most preferred to travel to the settlement at a later time, and if that was the case, Dr. Sharp often made arrangements with the local chief for their transport to the island.¹⁷ Miss Laing’s safaris in Teso, Lango, and Acholi were also the impetus for most new admissions at Kumi, and most of these patients travelled to the settlement of their own accord, although this was partially because Laing could only fit a small number of leprosy patients in her car when she was travelling over a distance.

At both CMS settlements, the annual intake of new patients was tied closely to the number of medical safaris taken during the year. When Miss Laing was unable to take many safaris, because of the high cost of petrol during wartime or because she was away on furlough, admissions at Kumi dropped drastically.¹⁸ She especially credited her ‘personal visiting in the villages’ with bringing children in the early stages of leprosy to the settlement, as their symptoms had not yet developed to a stage that locals would have conceived or recognised as leprosy.¹⁹ Of the 72 new admissions to Lake Bunyonyi in 1933, five came of

¹⁵ RCA, Kumi Annual Report, 1949.

¹⁶ UGA, J6/25I, Innes Report 4; SDA, X/NAF/9, Letter from DC Teso to M. Laing, 28 April 1945; Leprosy Mission, 118/16, Ngora Leper Mission Annual Report, 1928.

¹⁷ ‘A Leper Settlement on Lake Bunyonyi’, *Uganda Herald*, 28 July 1933; R. Langley, ‘Letter’, *Ruanda Notes*, 45 (July 1933), 12; Interview with Mary Sharp, 4 November 2009.

¹⁸ Leprosy Mission, 119/5, Letter from A. Kent to Miller, Leprosy Mission, 29 September 1948.

¹⁹ RCA, Kumi Annual Report, 1947.

their own volition, and 67 after meeting with Dr. Sharp on safari.²⁰ The FMSA missionaries at Nyenga and Buluba, on the other hand, did not start taking regular medical safaris until the 1950s, most likely because their settlements were smaller in size and already overcrowded, and because leprosy was a well recognised and feared disease in Buganda and Busoga, which made it more likely that chiefs would send in leprosy sufferers for admission of their own accord.

Although the CMS missionaries used medical safaris to locate potential leprosy patients and make them aware of the leprosy settlements and their purpose, the decision to enter the settlement was left to the individual patient, their family, and their Chief. The delay between a missionary's visit and the journey to the leprosy settlement could indicate that the leprosy patients needed time to consider what course to follow, and to arrange their affairs before they left. It could also indicate, however, that the decision to enter the leprosy settlement was not a personal one, but rather the result of pressure from kin or people in positions of authority within the community. In a different case, in 1946, the government began a voluntary resettlement scheme in Kigezi, to alleviate agricultural pressure on densely populated land by encouraging people to move away to less populated areas, such as nearby Ankole. Many resettled because they perceived economic benefits, but in some cases people relocated under pressure from kin who had stronger claims to the family land, or from chiefs who would gain political or economic benefit from their resettlement.²¹ The same could easily have been true of leprosy patients, not only in densely populated Kigezi, but across Uganda. In fact, although former CMS mission doctor J.E.H. Cook noted, after a visit to Lake Bunyonyi in 1938, that of the 93 infectious leprosy patients that he spoke with, only three informed him outright that they were there under duress, one because 'when his chief

²⁰ KDA, Medical 1930-39, Letter from L.E.S. Sharp to DC Kigezi, 6 July 1933.

²¹ Interview with John, 11 August 2011 (Lake Bunyonyi, 1960s, age 15); Interview with Vincent, 11 August 2011 (Kigezi, 1970s, age 25); KDA, Resettlement of Bakiga, Letter from Secretary General to Rwamuchucha, 6 September 1947; G. Carswell, *Cultivating Success in Uganda* (Oxford, 2007), 61.

advised him to go to Bwama for treatment, he took this to be a command', he added, 'It isn't always easy to distinguish between advice and moral compulsion, if the advice comes from one chief!'²²

Although theoretically, admission to a leprosy settlement was voluntary, small pieces of evidence remain indicating that some chiefs intentionally or unintentionally misinterpreted instructions from the DC to use 'every sort of active persuasion short of legal compulsion' to induce leprosy sufferers to go to the settlements, as instructions to compel leprosy patients.²³ Some local governments apparently created by-laws in the late 1940s that allowed for greater use of compulsion in sending leprosy patients to settlements, though this was definitively against the Medical Department's policy.²⁴ In 1946, a County Chief in Busoga wrote to his sub-chiefs that:

It is good to have that law passed so as to help the lepers have the hope of getting cured, also to try and prevent the spread of leprosy, and finally to make sure that the lepers have the letters of discharge from Buluba hospital. This would mean that if any leper is found with out that letter, he or she should go back to the hospital immediately.

Please make sure that those who try to insist, that the law will take its course and also ensure that this does not happen.²⁵

Not that chiefs who were so inclined needed a law enforcing the segregation of leprosy sufferers; in 1940, a chief in Busoga informed a village resident to enter Buluba or be repatriated: 'Written order to Eriezer Mudoola, calling on law that authorises him to expel any body with unbecoming behaviour, I order you to leave this village and then go to Buluba, and if you don't go there you will be sent back to Bugabula where you got leprosy from'.²⁶

Further evidence that leprosy patients feared they would be compelled to enter a leprosy settlement lies in stories from Kigezi, such as a leprosy sufferer killing himself 'when he

²² J.E.H. Cook, 'A Visit to Three Leper Settlements', *Leprosy Review*, 11.2 (April 1940), 103.

²³ KDA, Medical 1930-39, Minutes of Uganda's BELRA Committee Meeting, 24 March 1930.

²⁴ RCA, Minutes of the BELRA Uganda Branch Meeting, 19 April 1951.

²⁵ Translation from Lusoga, JDA, Medical Leprosy, Letter from County Chief of Bukoli to Sub-county Chiefs, 29 July 1946.

²⁶ Translation from Lusoga, JDA, Medical Leprosy, Letter from Chief of Kigulu to Eriezer Mudoola, 14 August 1940.

heard all lepers were being taken away' and a growing tendency for leprosy sufferers to hide from visiting doctors.²⁷ Incidentally, the intentional concealment of leprosy was rarely reported as a problem in Kigezi before 1950, only in Busoga and Buganda where the stigma towards leprosy was higher. Upon a request to summon all leprosy patients in the area for a visit from leprologist Dr. Innes, one chief wrote to the DC:

There are lepers who are well known, but come frequently to gathering like when Dr. Sharp came to check on them they ate and drank with the other people. Usually for self-defense they are holding spears, sticks and pangas. At Kayonza lepers of that kind are present, we tell them to go to Bwama and they refuse, what can we do to them? I kindly request this to be considered before Dr. Ross Innes comes here.²⁸

If groups of leprosy patients felt the need to come armed to meetings with doctors, it seems unlikely that admission to a leprosy settlement was always perceived as strictly voluntary. One elderly man, native to Ongino, recounted that the missionaries 'requested the local government chiefs to help them, mobilize patients, to arrest them for them'.²⁹ Missionaries and government officials called this 'friendly pressure' and 'moral persuasion', but what it often amounted to was compulsion.³⁰

Indeed, chiefs were very influential in sending leprosy patients to the settlement, even outside the purview of mission medical safaris. From the outset, FMSA missionaries at Nyenga and Buluba relied upon district officials and chiefs to send in new leprosy patients, often on their own initiative. In 1950 a Buluba missionary reported that almost every day, a leprosy patient arrived at the settlement with a letter from their gombolola chief.³¹ Sometimes patients made this decision of their own accord, without pressure or compulsion being applied, but even so the introductory letters accompanying many of the patient files at Buluba indicate the extent to which chiefs in Busoga, at least, were involved in the admission

²⁷ KDA, Medical 1930-39, Letter from Chief to DC Kigezi, 5 February 1931; Innes, 'Leprosy in Uganda', 281-2.

²⁸ Translation from Rukiga, KDA, Leprosy and Bwama Leper Colony, Subcounty Chief Kinkizi to DC Kigezi, 30 January 1950.

²⁹ Interview with David Livingstone Oitamong, 7 July 2010.

³⁰ Leprosy Mission, 6/14, Letter from to Sharp to Leprosy Mission General Secretary, 19 July 1928; SDA, X/NAF/9, Letter from DC Teso to M. Laing, 28 April 1945.

³¹ RCA, Buluba Annual Report, 1950.

process.³² The DC and District Medical Officer (DMO) also played a role in facilitating the admission of new patients into the leprosy settlement, often arranging for chiefs to send in a 'lorry load' of leprosy patients from their village, or handling the admission of leprosy patients who had previously been employed by the colonial government.³³

Some of the persuasion that chiefs applied to leprosy patients was probably for economic or political reasons, for example as an excuse to expel someone whose land could then be used, or perhaps as a means of currying favour with the DC. In Kigezi the only former leprosy patients who faced violence when they returned from the settlement to their homes were those who aggressively sought to reclaim land taken in their absence, which suggests that kin, community members, or chiefs might have had economic motives to 'persuade' a patient to leave home.³⁴ More influential, however, was a rising fear of leprosy across Uganda. Whereas most new admissions to leprosy settlements in Teso and Kigezi followed medical safaris, for which the DC specifically asked for chiefs' aid, in Buganda and Busoga, where leprosy was feared, some chiefs were anxious to expel leprosy sufferers from their midst. As one FMSA missionary observed, 'It seems likely from the numbers sent to us by the chiefs themselves, those chiefs are anxious to segregate the lepers in their districts, or at least to get them sent somewhere where they will be treated'.³⁵ A Muganda also recounted: 'I did not come here because I will...It was the chiefs who collected the patients suffering from leprosy'.³⁶

At Lake Bunyonyi and Kumi, when missionaries wrote of chiefs taking their own initiative in sending leprosy sufferers to the settlements, they often connected this with the

³² Translation from Lusoga, JDA, Medical Leprosy, Letter from DC Busoga to Sub-County Chief Kitayunjwa, 2 August 1944.

³³ Leprosy Mission, 119/5, Letter from DC Teso to M. Laing, 12 December 1944.

³⁴ Interview with Pat Gilmer, 4 November 2009.

³⁵ JDA, Medical Leprosy, Letter from Mother Solano to DC Busoga, 9 October 1945.

³⁶ Interview with Doreen, 30 April 2010 (Nyenga/Buluba, 1944, age 18).

growing awareness that the Iteso and Bakiga had about the contagion of leprosy. Dr. Sharp wrote, for example, that

The chiefs are also helping us by persuading the leper to come. This interest is most due to a small book written by Dr. Sharp and printed by the Government warning them of the dangers of contagion in such acts as, smoking each others pipes, sleeping under the same blanket as a leper, eating food from the same dish, using the same mat. As all these things were the customs of the people, they did not realise their danger. Now they are aware of it, they all seem anxious to assist in the work of segregating the lepers in their own particular village.³⁷

Missionaries at Kumi also related increases in patient admission to the positive effects of leprosy propaganda, both in convincing patients that they needed to come for medical treatment, and making them aware that leprosy was contagious.³⁸ Miss Laing wrote that:

Only a few days ago a man came to me and offered me the care of his five (so far) untainted children...This, again, shows a great step in advance, the fact that the parents are willing, and even come of their own account to offer their children for our care and attention in this way proves that they are learning the importance of segregation and good feeding and by hygienic surroundings.³⁹

In teaching the contagion of leprosy and the need for segregation, the missionaries intended to decrease the incidence of leprosy by persuading leprosy sufferers to enter the settlements. But a side effect of this propaganda was that by singling leprosy out and providing government officials with an opportunity to remove leprosy patients from the community, missionaries created an environment that made discrimination towards leprosy patients potentially beneficial, not necessarily for reasons of public health, as they intended, but also for political, economic, or social gain. This increased the likelihood that leprosy sufferers would be compelled by their relatives or chiefs to enter the settlement.

Entering a Leprosy Settlement by Choice

Although some leprosy patients acted under pressure or compulsion in entering a leprosy settlement, others did so of their own accord, for their own economic, social, and

³⁷ Birmingham, CMS/G3/AL Rosa Langley 1932.

³⁸ RCA, Kumi Annual Report, 1946.

³⁹ Leprosy Mission, 119/4, Letter from M. Laing, 9 November 1936.

medical reasons. Because admission was ultimately voluntary, the missionaries had to create incentives attractive enough to persuade leprosy sufferers to leave their home and often their family, and then to remain in the settlement, possibly for many years. Most of these incentives were positive in nature, such as offers of material support, poll tax exemption, specialised training, and biomedicine. Some were more negative, as has been discussed, such as educational propaganda that emphasised the contagion of leprosy and had the potential to create a fear of its sufferers.

Most of the elderly Ugandan leprosy patients interviewed for this research recounted their entry into the leprosy settlement as a decision taken by a family member, who believed that they might derive some medical benefit from the treatment that the missionaries provided. Often, this decision was the product of lengthy debate among family members, some of whom did not perceive the leprosy settlement as a viable medical option, or did not want their relative to go away for such a long time.⁴⁰ Such debates are in keeping with a wealth of anthropological research on health in Africa, which suggests that most medical decisions were made by a therapy group, rather than solely by the individual.⁴¹ If the family eventually decided that the leprosy patient should enter the settlement, a parent, grandparent, aunt, uncle, or sibling would then accompany them, even if the leprosy sufferer was an adult capable of making the journey alone.

Some leprosy patients entered the settlements ‘to be cured’, having used traditional medicine for at least a year before entering the settlement and finding it did not work, or that it made their symptoms even worse.⁴² At Buluba, the doctor or nurse who examined each leprosy patient before admittance asked them how long they had suffered from the disease.

⁴⁰ Interview with Silve, 22 April 2010 (Buluba, 1955, child); Interview with Pulekeria, 26 July 2010 (Nyenga 1949, age 9); Interview with Margaret, 6 July 2010 (Kumi, 1970, age 27).

⁴¹ Feierman, ‘Struggles for Control: The Social Roots of Health and Healing in Modern Africa’, *African Studies Review*, 28.2/3 (1985), 73-147; J. Janzen and W. Arkininstall, *The Quest for Therapy: Medical Pluralism in Lower Zaire* (Berkeley, 1978).

⁴² Interview with Tom, 22 April 2010 (Buluba, 1954, age 6).

125 records exist of patients discharged in 1948 and 1949, and of the 78 percent who answered this question, the average amount of time between the onset of leprosy symptoms and entrance into the settlement was 2.1 years. The missionaries' biomedicine was not the first choice of treatment that most leprosy patients pursued, and often it was the last. For example, missionaries continuously lamented the large number of patients who did not come to the settlement for treatment until they had developed a permanent deformity.⁴³ For the Baganda, delaying settlement entry until visible disfiguration had occurred was also delaying an undeniable and stigmatising connection to leprosy until the evidence was indisputable.⁴⁴

Some leprosy sufferers chose to enter, or at least to remain living in a leprosy settlement, because of the material and economic advantages it offered. Although able-bodied leprosy patients were expected to cultivate their own food, patients at each of Uganda's leprosy settlements were given clothing, soap, supplementary food, and other material goods and small luxuries. Upon being asked how she remembered the settlement, one patient recalled: 'When I came to Nyenga, they gave me free medicine, free food, free clothing, so I do not regret why I was brought to this place'.⁴⁵ Such reminiscences were common in interviews, if most likely coloured by more straightened contemporary circumstances. A former child patient at Kumi, for example, recalled that there used to be 'everything you wanted', like sodas and sugar.⁴⁶ Destitute leprosy sufferers were probably the most likely to choose to enter the settlement because of its material benefits. On one occasion, a CMS missionary linked the terrible physical condition of ten unsolicited new in-patients to a shortage of food in the area.⁴⁷ In addition, many leprosy sufferers were keen to take advantage of the colonial government's poll tax exemption for leprosy patients. Some tried to pretend leprosy in order to gain this exemption, but ultimately such attempts were

⁴³ FMSA, e. Nyenga, Nyenga Annual Report 1943; *BELRA Quarterly* (April 1950), 30.

⁴⁴ JDA, Infectious and Contagious Diseases, Letter from Mother Jacoba to DC Busoga, 14 January 1949.

⁴⁵ Interview with Margaret, 26 July 2010 (Nyenga, 1949, age 10).

⁴⁶ Interview with Michael, 6 July 2010 (Kumi, 1952, age 10).

⁴⁷ Birmingham, CMS/G3/AL Grace Mash 1950.

futile because by the 1940s, this exemption was only granted if the individual could prove they had been treated for leprosy at one of the mission settlements.⁴⁸

Educational opportunities were another reason to enter, or remain living in, a leprosy settlement, and as discussed in Chapter 4, parents were far more likely to send their children to a leprosy settlement for treatment if they believed schooling was available to them. Any patient who wished could learn to read and write, and those whom the missionaries deemed especially intelligent or responsible were given the opportunity to learn trades such as carpentry, brick-laying, tailoring, teaching, nursing, or midwifery, which they could pursue outside of the settlement when their treatment was complete. At Kumi, a number of young men and women asked to stay at the settlement even though they had been pronounced fit for discharge, because they wished to continue attending school.⁴⁹

The Isolation of Leprosy Patients?

Contrary to the popular stereotype that casts leprosy settlements as total institutions where leprosy sufferers were isolated from the rest of the world, the social borders of Uganda's leprosy settlements were quite fluid. Visitors entered the leprosy settlements for out-patient biomedical treatment, trade, governance, and stays with family and friends, and in turn most leprosy patients were allowed to go and visit their families as often as once a year, or more frequently in times of family crisis.

The most frequent cause for which leprosy patients were permitted to leave the settlements was in order to attend local markets and purchase food or other goods. As the settlements grew in size, missionaries and patients were able to cooperate in building markets or stores within each settlement, so that patients would not have to travel any great distance to purchase their necessities. However, for the first ten or fifteen years of each settlement,

⁴⁸ JDA, Medical Leprosy, Letter from DC Busoga to Secretary-General, 22 September 1944; JDA, Medical Leprosy, Letter from Sr. Felicity to DC Busoga, 14 June 1945.

⁴⁹ 'Conquering Disease: The Fight Against Leprosy', *Mission Hospital* (1940), 9.

most purchases were made by individual patients, externally. Supplementary rations of food were regularly provided, especially in times of famine, but for the most part the missionaries paid patients for their labour, or gave them money during their first few months at the settlement while their crops grew, and patients then used that money to buy their food at the market. At the CMS leprosy settlements, patients who wished to be evangelists were also allowed to leave the settlement at will, in order to visit their nearby congregations, and on some occasions they were even given permission to live with their congregations for several months, if another teacher could not be found.⁵⁰ Select patients were also allowed to leave the settlements to perform such tasks as the gathering of firewood.

Beyond the economic and evangelistic necessity of allowing patients to leave the settlements for buying, selling, gathering, and preaching, patients had to ask permission of the missionaries in order to leave. Patients could, of course, 'abscond', but if they wished a guarantee that they could return to the settlement, then they needed to seek permission to visit their family or friends. At Lake Bunyonyi, the missionaries would grant leave to those patients who requested it for ostensibly worthy reasons, for example: 'Now and again they ask for permission to go home to see a dying relative (a useful excuse for they seem to die most conveniently again and again)'.⁵¹ At the time of Bunyonyi's annual survey in 1947, 27 of the island's 809 leprosy patients were away on leave. Broken down by age and gender, that was 4.1 percent of the men, 2.9 percent of the women, and 2.6 percent of the children.⁵² A similar overall portion of leprosy patients were absent during annual surveys in 1948 and 1949, though as the years passed there was a gradual increase in the proportion of men on leave, and a decrease in the proportion of children absent.⁵³

In the early years at Kumi's adult settlement, patients would:

⁵⁰ R. Langley, 'Diary Gives a Vivid Account of Life on the Leper Island', *Ruanda Notes*, 58 (October 1936), 23.

⁵¹ Birmingham, CMS/G3/AL Beatrice Martin 1934.

⁵² RCA, Bunyonyi Annual Report, 1947.

⁵³ RCA, Bunyonyi Annual Reports, 1948-51.

Come and go at will and stay away as long as they like. At the cotton season, for instance, numbers leave to make a little money, and return for treatment when the excitement is over. During the rains many go away again to plant potatoes; while others wander off to attend a family law court or a funeral, and stay away until they are feeling thoroughly ill.⁵⁴

As the settlement became better established and stigma towards leprosy grew in Teso, patient absences decreased in number, but through the 1940s there were several patients who came and went with the season.⁵⁵ As at Bunyonyi, some patients did formally request leaves of absence, which improved the likelihood of a good relationship between the patient and missionaries, and could help in the avoidance of property and financial disputes upon the patient's discharge.⁵⁶

Leprosy patients at Nyenga and Buluba were also granted leave on request, and similarly to the CMS settlements, 'You could go without permission but when you come back they would just send them away, they would say, go back forever'.⁵⁷ Patients at Nyenga were allowed two or three weeks to visit their families after Christmas, and patients at Buluba were allowed two.⁵⁸ If patients were not well enough to travel home of their own accord, the missionary Sisters would even arrange transportation for them: 'Visitation was timely but very free, for my case, the Sisters would arrange and take me home and then back since I had become blind'.⁵⁹ No count remains for Nyenga, but when Dr. Muir came to visit Buluba in 1938, nine percent of the patients were away on leave.⁶⁰

Each leprosy settlement received a steady flow of visitors who did not suffer from leprosy. At Lake Bunyonyi, the greatest volume of visitors came to the settlements as out-patients, for such ailments as malaria, pneumonia, dysentery, and ulcers. 40-60 people came

⁵⁴ Leprosy Mission, 118/16, Letter from A. Downes-Shaw to Anderson, Secretary, Mission to Lepers, 12 June 1933.

⁵⁵ SDA, X/NAF/9, Letter from Laing to DC Teso, 14 June 1947.

⁵⁶ Birmingham, CMS/G3/A10/m1A, Interim Progress Report, Kumi, 1950.

⁵⁷ Interview with Francis, 27 July 2010 (Nyenga, 1953, age 18).

⁵⁸ Interview with Yoana, 28 April 2010 (Buluba, 1947, age 4); Interview with Tom, 22 April 2010 (Buluba, 1954, age 6); Interview with Margaret, 26 July 2010 (Nyenga, 1949, age 10).

⁵⁹ Interview with Doreen, 30 April 2010 (Nyenga/Buluba, 1944, age 18).

⁶⁰ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938.

daily from around the lake and mainland, or about 10,000 annually, and there was an ‘untainted’ nurse whose entire duty was to look after these patients.⁶¹ At Kumi, one of the CMS nurses spent part of her time at a nearby dispensary, and while out-patients were not treated in the same medical buildings, the two medical enterprises were in close proximity and shared staffers.⁶² At Nyenga and Buluba, there were between 100 and 400 out-patients attending for leprosy treatment, and locals also came to the hospital at Buluba for the treatment of such illnesses as syphilis, gonorrhoea, and sleeping sickness.⁶³ Many leprosy patients also received regular visits from family and friends, especially if they did not have to travel too great a distance to visit, and indeed many patients chose which settlement they would enter on the basis of whether they had a relative living nearby.⁶⁴ All of the leprosy patients interviewed recalled that, before their relatives had died, they used to visit and send gifts; the only exception was two Bagisu leprosy patients interviewed at Kumi, who said nobody ever bothered to come and visit them.⁶⁵ One possible explanation for this severance of family relationships lies in the distance that Bagisu would have to travel to visit their relatives at Kumi, though this did not stop Karamajong patients from receiving visitors. A more likely explanation is perhaps that:

The Bagishu are the most leprosy-conscious tribe served by the Settlements. Although not actually ostracised, the leprosy patient is often unpopular in his community, and sometimes even members of his own family refuse to have intercourse with him or with his children, even when the latter have no signs of the disease.⁶⁶

Finally, leprosy patients also received regular visits from missionaries, foreign visitors, colonial government officials, and local Ugandan government officials or leaders. For

⁶¹ Birmingham, CMS/G3/AL Rosa Langley 1932.

⁶² Birmingham, CMS/M/Y/A10/A, Letter from CMS Medical Committee to Dr. Hunter, 10 December 1931.

⁶³ RCA, Nyenga Annual Report, 1950; RCA, Buluba Annual Report, 1950; Interview with Doreen, 30 April 2010 (Nyenga/Buluba 1944).

⁶⁴ Interview with Demetria, 28 April 2010 (Buluba, 1961, age 30).

⁶⁵ Interview with Paulo, 7 July 2010 (Kumi, 1952, age 20); Interview with Margaret, 6 July 2010 (Kumi, 1970, age 27).

⁶⁶ RCA, Kumi Annual Report, 1949.

example, the Kabaka of Buganda came to visit Nyenga several times, and the Kyabazinga of Busoga was even more involved in Buluba's affairs and maintenance.⁶⁷

Local Relations and Attitudes towards the Missionaries

As the settlements did not and could not exist in isolation, their patients and staff formed relationships with members of the local communities, both adversarial and friendly, which then influenced the way that the missionary superintendents were locally perceived and remembered. Indeed, the relationship between leprosy settlement and the local community was often strongly influenced by the personality of the missionary superintendent and the local attitudes towards leprosy.

The leprosy settlement at Lake Bunyonyi does not seem to have caused a great deal of local consternation or conflict, perhaps because it was founded on land that had already been cleared due to the Nyabingi cult; because leprosy was not feared in Kigezi; and because the missionaries offered biomedical treatment to locals. The local chief of Ndorwa was most heavily involved in the settlement, from ensuring that enough people brought food to the local market for the leprosy patients to buy, to assenting to the appointment of the settlement's headman.⁶⁸ The most consistent cause of conflict between the settlement and local communities was land. In addition to Bwama Island, the leprosy settlement had a plot for cultivation on the mainland, and in 1944, the chief of Ndorwa gave 20 people permission to farm land just inside the 'quarantine' area where the leprosy patients farmed. Then, according to the chief:

There came 19 people from outside that were not allowed to farm inside there and they asked the 20 people the owners of that land whether they can give them small farmland to help them grow sweet potatoes and those 20 people allowed them to farm; Now I have already authorized them that once they harvest their crops they should stop farming there again...Also I have already seen Mr. Sharp and he asked to be

⁶⁷ FMSA, e. Nyenga, Nyenga Annual Report 1944; JDA, Medical Leprosy, Many letters between to and from the Kyabazinga.

⁶⁸ Translation from Swahili, KDA, Leprosy, Letter from Chief of Ndorwa to DC Kigezi, 19 March 1941; Translation from Swahili, KDA, Leprosy, Letter from DC Kigezi to Chief of Ndorwa, 2 July 1941.

allowed to farm on another section that was given to the 20 people on that land that they are leasing to people from outside; and me I disagreed.⁶⁹

Along with the DC, the Ndorwa chief was frequently put in a position of negotiating between local Bakiga and the leprosy settlement over the use of land.

There were also issues over customary land, for example in 1945, when another group of people came inside the settlement's land, built houses, and started cultivating. The chief of Ndorwa wrote that:

When I met them they informed me that the valley belonged to the people that have built inside the quarantine and a few others that have built outside the quarantine, when I called them and asked them about the valley they told me that the valley has been theirs from the past, and then I told them that the valley would be taken by the lepers because it has taken long without any farming taking place on it, in reply, they disagreed.⁷⁰

If these customary land owners were to be moved off the land, they thought the leprosy settlement should buy the houses they had built, which then occasioned a lengthy discussion between the Ndorwa chief, Bwama's chief, Dr. Sharp, and the DC over the form and cost of compensation.

The issue of customary land came up again in 1950 when the CMS' 21-year lease on Bwama Island came up for renewal. The mission asked for another 21-year lease, which would also include the neighbouring Bushara Island. The Ndorwa County Chief wrote:

We must appreciate the fact that the land in question is owned customary and is therefore passed on from generation to generation but also the lepers who have to be cured are also born here...I request that this issue be forwarded to the Council of Chiefs of Kigezi for thorough thought and final decision because me – as an individual cannot commit the entire Kigezi region on land that belongs to the people of Kigezi.⁷¹

The Chief of Ndorwa was inclined to grant this request, but not everyone felt the same about the mission's claim to land:

I take a stand based on the good of our people. I strongly object that Bushara be given to the missionaries outright and be considered part of Bwama even though there

⁶⁹ Translation from Swahili, KDA, Leprosy, Letter from Chief of Ndorwa to DC Kigezi, 7 February 1944.

⁷⁰ Translation from Swahili, KDA, Leprosy, Letter from Ndorwa Chief to DC Kigezi, 12 April 1945.

⁷¹ KDA, Leprosy, Letter from Chief Ndorwa to DC Kigezi, 20 May 1950.

is need to construct houses now reason being in the near future there will be no need as the years progress. In my wisdom I think it is better they be given a yearly occupancy license to stay there that is renewable at the end of each year where they shall apply annually.⁷²

According to Reverend Kimote, who was the child of a Bwama leprosy patient, a teacher at the school, and later a pastor on the island, people were quick to forget what the mission doctors did for the Bakiga in ridding the district of leprosy, and would agitate to take back their own land, sometimes even threatening to fight. The settlement's staff was particularly incensed when one former leprosy patient, who was treated at Bwama for years and returned home symptom-free, then tried to take the mission to court for the return of his land.⁷³

Although disputes over land became increasingly common from the 1940s onward, many locals held the settlement and its missionaries in a more positive light, as did the apparent majority of the patients within the settlement. Dr. Sharp, who founded Bwama and spent so many years working there, is still remembered around the lake for his healing work, and in all the praise that the missionaries heaped upon each other, Dr. Sharp was presented as particularly beloved and respected by leprosy patients. He reputedly represented something of a father figure to some patients, and two of the nicknames he was given, translated from Rukiga into English were 'Mr. Eyebrows' and 'king'. His wife's nickname was *Kirungi*, which meant good and kind.⁷⁴ The settlement's lady missionaries formed particularly strong relationships with many leprosy patients, since they lived on the island and worked alongside them every day. When Miss Horton's father died in 1932, some patients brought her small gifts to comfort her in her sorrow, as was the Bakiga custom.⁷⁵ When Miss Langley returned from her furlough in England, some patients embraced her in welcome.⁷⁶ The patients also saw these British missionaries and some of their ways as 'balmy', but this did not prevent

⁷² KDA, Leprosy, Letter to DC Kigezi, 1950, sender unknown.

⁷³ Interview with Reverend John Kimote, August 2009.

⁷⁴ Interview with Joy Gowers, 12 February 2010; R. Langley, 'Report of the Last Three Months', *Ruanda Notes*, 55 (January 1936), 29; Interview with Mary Sharp, 4 November 2009.

⁷⁵ R. Langley, 'Account of Answered Prayer', *Ruanda Notes*, 43 (January 1933), 11.

⁷⁶ R. Langley, 'Goes on Safari', *Ruanda Notes*, 46 (October 1933), 13.

them from developing respect for them.⁷⁷ One orderly who was in search of a wife asked for Miss Langley's assistance; nine women on the island that he had already asked had said no, but he felt sure that if Miss Langley asked for him, one would agree.⁷⁸ This could be perceived as a sign of the authority of the missionaries, but also as an example of the respect that many patients accorded them. The missionaries' opinions were also respected, or at least sought out, by non-patients. In addition to the thousands of out-patients who travelled to the settlement annually for biomedical treatment, local Christians also visited the settlement to ask the missionaries and Ugandan staff for advice about their teaching or local congregations, and to attend Christmas and Easter services.⁷⁹

Perceptions and memories of the first two decades of the leprosy settlements at Kumi and Ongino are tied to one figure in particular: CMS nurse Margaret Laing. Even before Miss Laing's arrival in 1932, many Teso chiefs were very cooperative in the commencement of leprosy work, for example building the dispensaries where out-patient treatment took place, enforcing the system of fines for non-attendance, and gathering local leprosy patients for surveys. Some chiefs even requested that a leprosy campaign be started in their county.⁸⁰ After her arrival, Miss Laing built a powerful reputation across Teso. Visiting leprologists Dr. Innes wrote that: 'Miss Laing has such influence on the surrounding people that lepers can be collected like that when she asks for it'.⁸¹ He also wrote that 'This Leper Settlement is by far the best I have yet studied in my work for East Africa. It is on sound lines and is firmly rooted in the affections and respect of the native peoples, and in addition to the work in its own confines'.⁸² Today, Laing is remembered both positively and negatively in the Kumi area.

⁷⁷ Interview with Mary Sharp, 4 November 2009.

⁷⁸ R. Langley, 'Last Letter before Leaving', *Ruanda Notes*, 62 (October 1937), 24.

⁷⁹ M. Forbes, 'The Leper School and its Joys and Sorrows', *Ruanda Notes*, 51 (January 1935), 18.

⁸⁰ Leprosy Mission, 118/16, Minutes of Teso Leprosy Sub-Committee, 2 May 1929.

⁸¹ UGA, J6/25I, Innes Report 4.

⁸² Birmingham, CMS/G3/A10/m1A, Letter from Rev. Calcraft to Hooper, 4 January 1948.

When the CMS missionaries began work in Kumi and Ongino, they were feared because of their perceived connection to the Baganda, who ‘carried guns a round which was scary’.⁸³ Many of the early evangelists and hospital staffers in Teso were Bagandan, so the link was a logical one for the Iteso to make, and it was largely the Bagandan soldiers, under Kakungulu, that had conquered Teso for the British.⁸⁴ Miss Laing, with her forceful personality and sometimes domineering ways, became the focus of fears about entering the leprosy settlement. Rumours and suspicion swirled around her, as one elderly man, David Livingstone Oitamong, who lived near Ongino and had met Miss Laing, and his wife recounted: ‘At first when it was Laing alone, they used to fear because at times they would strangle some of them. But they had a perception that even if they were going to die and you went for treatment, they would strangle you to finish you up’.⁸⁵ David added:

They say that if you produced a child, when you were a leper, they would take the child to where you don’t, you know, and some people have wrestled their children to death. So that also scared people. That maybe the settlement was for stealing people’s children...Now when Dr. Wheate came in...Now people started coming freely cause at least the reception was now good. It wasn’t as harsh as that those days of Laing, where you bear a child and it’s taken, and you don’t see the child, where they felt that, even if you were ill, they would strangle you to finish you up, so that you die very fast. You don’t infect others. Laing used to be a very tough lady. She could just beat you. That if you refused to give her your child. But Laing, you know people, there’s a kind of fungal infection, where you would develop patches, so if Laing, if she saw that kind of patch on your skin, and she came here, and you say, no, that is not leprosy, she would strangle, beat you, the owner of the child, and take the child by force.⁸⁶

But, he added, ‘Laing did good, she had come to save people, but people didn’t know because people were ignorant in those days’.⁸⁷ Another leprosy patient recounted similar rumours about Miss Laing, which his father had heard: ‘There was rumour going around that the doctor who was here, Dr. Laing...that she used to be a harsh woman, would beat children, so his father feared to bring him [to Kumi]. In fact that maybe if you brought him, Laing would

⁸³ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

⁸⁴ M. Twaddle, *Kakungulu and the Creation of Uganda* (London, 1993).

⁸⁵ Interview with Ademeus, 7 July 2010.

⁸⁶ Interview with David Livingstone Oitamong, 7 July 2010.

⁸⁷ Interview with David Livingstone Oitamong, 7 July 2010.

beat him, would even beat his father, because she was a tough lady'.⁸⁸ According to Luise White's analysis of vampire stories and rumours in colonial Africa, such rumours about the dangers of entering the leprosy hospital can be understood as an expression of the anxieties and uncertainties that the Iteso felt about the presence of a medical mission in their midst.⁸⁹ It is unsurprising that negative rumours about the leprosy settlement would abound, given that the missionaries arrived in the area with the Baganda, who were already feared by the Iteso; opened a hospital for a disease that was not known to exist; commenced treating patients with painful and regular injections; and adopted a host of socially controlling measures such as the separation of babies from infectious parents.

Even outside connection to the leprosy settlement, Miss Laing had a powerful and rather negative reputation:

She was a tough lady, she would just beat you with her hand. Even when she was moving in her car, and she gets cows on the way, she would get down and fight you...Laing would get you herding cows and you have a stick, she would get the same stick for beating you, she used to be a very tough lady. That's why she was feared. That's why when she would come to get leprosy patients, people would run away.⁹⁰

And another Kumi native added:

My father used to tell me, that one time Laing, you know people used to bath in the swamps. They bathed just like that, Laing, one time came, caught somebody bathing by the roadside with that flowing water, the running water on the swamp. So she got down and hit them, and so the man did also, boxed Laing, boxed her down.⁹¹

Margaret Laing was obviously a woman of extremely forceful character, and well known in the region. No written records are available to confirm any of these rumours of beating, but families did feel forced by Laing to part with their children, and she did take babies from infectious parents. Her reputedly violent behaviour, though well-remembered in rumour, is probably an exaggeration, perhaps growing from a discomfort with a woman creating a

⁸⁸ Interview with Lawrence, 6 July 2010 (Kumi 1959).

⁸⁹ L. White, *Speaking with Vampires: Rumor and History in Colonial Africa* (Berkeley, 2000), 89-121 (Chapter 3: "Bandages on Your Mouth")

⁹⁰ Interview with Ademeus, 7 July 2010.

⁹¹ Francis Okwi, 7 July 2011.

position of such perceived power and authority for herself. Laing certainly did not perceive herself to be well-liked by all in Teso. On receiving a request to travel to Rappayi and inspect the population for leprosy sufferers, she wrote to the DC: 'I have just received the enclosed anonymous letter. I never take any notice of such letters. There is probably some sport of revenge about it'.⁹² Why she felt she might be the target of vengeance is unclear, but from her letter to the DC, it is evident that she had previously received anonymous letters asking her to visit certain villages, only to find later that it was a hoax.

In spite of all these rumours, Miss Laing was apparently well loved by the majority of Kumi and Ongino's residents, though some had quarrels with her. Sicola, one of the earliest child patients at Kumi, remembered Laing bitterly for taking her bridewealth and thereby severing her relationship with her family, and for taking her child away, but she also said that Laing became like her own mother.⁹³ This sentiment was echoed by other leprosy patients, recorded by fellow CMS nurse Adelaide Kent when Miss Laing arrived back in Teso after a long furlough:

The most touching and inspiring welcome was from the Adults at Ongino, as they all crowded round young and old, blind crippled disfigured with their disease, and fell on their knees (a sign of affection as well as respect) to greet her, their poor disfigured faces alight with joy that their "Mother" had come back to them. "Why, she still remembers our names" said more than one.⁹⁴

When Laing left the settlement in 1948, so too did a number of Ongino's long time adult residents. Miss Kent wrote:

I am afraid some of our older patients, adults, have felt they have lost their friend and have wandered away, this is only to be expected when one who has done so much for them has had to give up. I feel sure that this is only temporary and they will soon realise they have another friend in Dr. Wheate.⁹⁵

So while Laing's relationships with patients were not without turmoil, such you might find in any community or among any family, and while she was feared by many Iteso, she was also

⁹² SDA, X/NAF/9, Letter from Laing to DC Teso, 18 September 1947.

⁹³ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

⁹⁴ Leprosy Mission, 119/5, Letter from Kent to Millar, Leprosy Mission, 29 January 1947.

⁹⁵ Leprosy Mission, 119/5, Letter from Kent to Miller, Leprosy Mission, 29 September 1948.

respected. David said that: ‘Laing is a very good person, she was committed to her work, to me she excelled, with her commitment. I’m always grateful to give respect every other European if he or she maybe has a heart like Laing’.⁹⁶

Although elderly leprosy patients at Nyenga today do not recall having had a negative relationship with the people who lived around the leprosy settlement, mission and government records from the 1930s and 1940s indicate that the neighbouring community was never happy to have a concentration of leprosy patients in their midst. According to Mother Kevin, the local chiefs were very excited about the opening of the leprosy settlement, and they did provide *luwalo* labour for it in its early years.⁹⁷ It was those who lived in close proximity to the settlement who initially feared and disliked it. Leprosy patients were not permitted to leave the settlement proper in search of firewood, because the locals objected to leprosy sufferers moving in their midst.⁹⁸ Someone put up a sign near the settlement saying “Toyita wano” (Do not [come] this way). Some of our “cleaner” neighbours objected to the close proximity of the outcasts’.⁹⁹ Nyenga treated a high volume of leprosy out-patients, and many who travelled from great distances tried to find nearby accommodation to alleviate this problem, but ‘it is becoming more and more difficult for patients to obtain nearby accommodation even very light cases are objected to. It seems to be the general opinion that all lepers are highly infectious and that all should be accommodated in the camp’.¹⁰⁰ Moreover, the Buganda Native Administration (NA) contributed very reluctantly to the leprosy settlement. They promised a small annual grant, more than Kumi received from the Teso NA, but less than Lake Bunyonyi and Buluba received from the Kigezi and Busoga

⁹⁶ Interview with David Livingstone Oitamong, 7 July 2010.

⁹⁷ Mill Hill Mission Archive, Freshfield, England, UGA 24, Letter from Nsambya Convent to Uganda Bishop, 2 January 1931; FMSA, e. Nyenga, Nyenga Annual Report 1934.

⁹⁸ FMSA, e. Nyenga, Letter from Nkokonjeru Convent, Lugazi to Acting Secretary, BELRA, 3 February 1933.

⁹⁹ JDA, Infectious and Contagious Diseases, Letter from Mother Jacoba to DC Busoga, 14 January 1949.

¹⁰⁰ RCA, Nyenga Annual Report, 1950.

NAs.¹⁰¹ But in some years, the missionaries complained that the NA never sent the promised annual grant, and they had to be pushed by the Medical Department to fulfil this financial responsibility.¹⁰²

Buluba's leprosy settlement had a better relationship with the locals who lived nearby, most likely because there was already an area of cleared land around the settlement, which acted as a buffer between the leprosy patients and their neighbours, and because leprosy was slightly less feared by the Basoga. As at Lake Bunyonyi, there were some conflicts with locals over the extension of the settlement's cultivation land. On one occasion, in 1946, a group of petitioners wrote a letter to the Kyabazinga asking that Buluba not be given more land:

We have received a command from our Sub County chief of Sabagabo, directing us that on this parishes; Baitambogwe and Nabulongo. The parish chiefs are to stop getting more tenants since they belong to the lepers of Buluba...Our complaint therefore is that the lepers have not even occupied the whole of Buluba land and yet they are being added more land. This however has paved the way for people to attack us from Bukalinti...But for us sir, we dearly request you to critically examine this complaint so that our parishes are not taken by the lepers since they still have enough land.¹⁰³

There were also instances when migrants took advantage of the presence of leprosy patients on the sleeping sickness cleared land. In 1941, a number of people were evicted from the area three miles north of Buluba as a sleeping sickness prevention measure after the recent outbreak. Shortly thereafter, these people complained to the government that leprosy patients were stealing their *matoke*, tilling their land, and occupying their huts, for which they had not been compensated. Upon investigation, the DMO found that the boundaries of the leprosy settlement's land had never been clearly defined, and 'leper' plots were interspersed with 'non-leper' plots, which caused confusion. In addition, fifteen arrested leprosy patients had

¹⁰¹ RCA, Kumi, Bunyonyi, Nyenga, and Buluba Annual Reports, 1947.

¹⁰² RCA, Minutes of the BELRA Uganda Branch Meeting, 19 April 1951.

¹⁰³ Translated from Lusoga JDA, Medical Leprosy, Men from Baitambogwe Parish to Kyabazinga, 28 August 1946.

been moved off their land at a sleeping sickness 'danger point', and they had penetrated a mile into the area that was supposed to be evacuated, which was possible because:

The control of these people by the Settlement Authorities appears to be very lax. In some few cases the owners of the plots have given permission for the Lepers to live on their plots and guard their plantain crop, but in the majority of cases this occupation is unauthorised and is causing a lot of disquiet among the evacuated persons. This position is made worse in that various employees of the Buluba Tile Factory, both domestic workers and casual labourers, are taking advantage of the laxity of control and are now living in the three mile limit.¹⁰⁴

Thus while there were sometimes disputes over land, complicated by the government's sleeping sickness measures, there was still positive interaction between some leprosy patients and their neighbours. For example, one can assume that if the evacuated individuals had been mortally afraid of leprosy and its contagion, they would not have asked leprosy sufferers to look after their home and crops. The same could be said for locals who came into the settlement for general biomedical treatment, or to use the settlement's chapel.¹⁰⁵

The real difficulties in relations between the leprosy settlement and Basoga came when the district government and missionaries began to discuss the possibility of moving the leprosy settlement from Buluba. The Busoga Standing Committee on Health was adamantly against all of the alternate sites proposed. Buluba, situated on a lakeshore and surrounded by evacuated land, was enough on the periphery to cause very little anxiety; indeed most of the settlement's immediate neighbours seem not to have minded the proximity of leprosy patients. The other sites and dispensaries mentioned as possible alternate locations were too close to 'the centre of the District and in the centre of the people'.¹⁰⁶ The Busoga Central Council decided that:

- If lepers are removed from Buluba to a place which is in the midst of people and closer to a dispensary in which people who are not lepers are treated, and when the lepers get a little better they will mix up with sound people or perhaps they will make friendships with sound people and the result will be that leprosy will spread than what it is at present.

¹⁰⁴ JDA, Medical Leprosy, Letter from DMO Busoga to DC Busoga, 2 August 1941.

¹⁰⁵ JDA, Medical Leprosy, Letter from DC Busoga to County Chief Butembe Bunya, 18 June 1944.

¹⁰⁶ JDA, Medical Leprosy, Minutes of Busoga Standing Committee on Health, January 1943.

- The council is of the opinion that lepers should not be treated in the same dispensary as the people who are not lepers. Because perhaps the things used in treating lepers such as needles etc. will be used in treating people who are not lepers and not only that but also to treat lepers in the dispensary will permit the lepers to have a closer contact with the other people who are not lepers.
- Under the above circumstances the Council unanimously decided that if it will be found impossible to leave the lepers at Buluba, the Government should procure a small island for a Leper Settlement to be established there.¹⁰⁷

The NA exhibited an uncompromising fear of leprosy and its contagion, which is at odds with the relative dearth of local complaints about the Buluba settlement, unlike at Nyenga. It is in keeping, however, with the apparent ambiguities in Basoga attitudes towards leprosy, for even as the NA suggested that an island would be a preferable alternate site for leprosy patients, they were also against the notion that Basoga leprosy sufferers should be treated outside Busoga.¹⁰⁸ And while a fear of leprosy led the Buganda NA to attempt to avoid any financial responsibilities for the settlement, the Busoga NA gave a £1800 annual grant to Buluba, which was a staggering amount, especially compared to the next highest NA grant, from Kigezi to Lake Bunyonyi at £155.¹⁰⁹

Conclusion

Although entering a leprosy settlement as an in-patient did distance leprosy sufferers from their kin and community, particularly if the settlement was far from their homes, life in Uganda's leprosy settlements was not as isolating an experience as stereotypes of leprosy would suggest. Patients, relatives, and local chiefs were involved in the decision of entry: a decision made in hopes of medical treatment, material support, or economic or political advancement, and not necessarily on behalf of the patient. Most leprosy patients remained in contact with their families after entry into the settlement, and although it was discouraged, patients were free to move over the settlements' borders in pursuit of their own social and economic priorities. Leprosy patients also came into regular contact with 'untainted'

¹⁰⁷ JDA, Medical Leprosy, Letter from DC Busoga to DMO Busoga, 11 June 1943.

¹⁰⁸ JDA, Medical Leprosy, Minutes of Busoga Standing Committee on Health, January 1943.

¹⁰⁹ UGA, J6/25I, Innes Report 3; UGA, J6/25I, Innes Report 5.

Ugandans within the settlement's boundaries, whether it was locals interested in trade, socialising, and out-patient biomedical treatment, or Ugandan authorities who were involved in day to day settlement life. From the mission perspective, leprosy settlements were an ideal opportunity to 'civilise' and evangelise Ugandans in relative isolation, but from the Ugandan perspective, leprosy settlements could be temporary residences in which to accumulate wealth and pursue health while maintaining kinship networks.

Chapter 6: The Other Side of the ‘Civilising’ Narrative: Patient Perspectives and Negotiations in Uganda’s Leprosy Settlements

While Uganda’s leprosy missionaries had a specific vision for the lives of the leprosy patients who were resident in their leprosy settlements, these residents were no *tabula rasa* on which the missionaries’ goals of civilisation and Christianity could be written. Life in Uganda’s leprosy settlements was a continuous negotiation between missionaries, Ugandan staffers, and Ugandan leprosy patients, as each pursued their own religious, economic, medical, and social priorities. The missionaries and their ‘untainted’ staff were few and forbidden the use of outright compulsion, and thus they relied upon leprosy patients for the maintenance of each settlement. These leprosy patients, who naturally had their own ideas about how life in the settlements could benefit them and what changes they were willing to make in order to take full advantage of those benefits, were therefore in a strong position to negotiate their priorities.

In order to bring out the voices of these men and women, this chapter draws on interviews undertaken primarily with elderly former leprosy patients who were living at the former leprosy hospitals of Kumi, Buluba, and Nyenga. As long-term residents of hospitals that have long received special attention from humanitarians, government officials, and medical and nursing students, these men and women are accustomed to being put on display as sufferers of leprosy. Less frequent, however, are outside visitors who wish to discuss their memories of leprosy and life in the mission settlements, and by and large these former patients were quite happy to discuss their memories and perceptions, though they may have been coloured by the passage of time, their expectations of what a foreigner might wish to hear, and their reliance on the missionaries and church for their support. Correlating patient interviews with colonial government records, and reading across extensive missionary accounts of Ugandan leprosy patients themselves, this chapter endeavours to construct a

glimpse of the physical, emotional, and social experience of leprosy in Uganda's mission settlements.

The chapter begins with a discussion of how the settlements' residents physically and emotionally experienced leprosy within the settlements, and how they perceived biomedicine and Christianity. It moves on to discuss their social experiences within the settlement, examining some of the issues over which missionaries and leprosy patients conflicted and negotiated, such as child separation and 'immorality', as well as some of the ways in which patients tried to take advantage of the economic opportunities settlement life offered. The CMS missionaries at Lake Bunyonyi, in particular, wrote more candidly about the disagreements and problems that they had with leprosy patients, and this chapter uses these mission records, as well as supplementary evidence from the other settlements, to highlight further points of conflict between missionaries, staff, and leprosy patients. It then concludes with a discussion of why and how patients came to leave the leprosy settlements, as most eventually did.

While the first four chapters of this thesis have dealt primarily with the priorities and agendas of the missionaries and government officials who ran and funded Uganda's leprosy settlements, this last chapter, along with Chapter 5, explores the priorities and perspectives of the patients themselves, and how they negotiated with the settlements' staff to shape their own lives, rather than simply reacting to the 'civilising' force of the missions.

The Physical Experience of Leprosy

As leprosy was a chronic and sometimes debilitating disease, some of the leprosy patients living in Uganda's leprosy settlements underwent painful physical and emotional experiences. While Uganda's leprosy missionaries professed a desire to preferentially admit leprosy patients in the early stages of the disease, so that they might be discharged without

deformity, in reality, when the settlements began to overcrowd, they preferentially admitted those in the advanced stages of the disease:

The majority were poor, filthy, and helpless enough...two of them were smothered in ulcers from head to foot, their poor little bodies maimed and legs doubled under them, so that unless... an operation is performed, they will never be able to walk...Another old woman...was literally smothered from head to foot in large patches of leprosy. Another woman, with her poor old face eaten away. It is useless for me to try and describe such pitiful sights. Lepers! No, no one has any time for them in their villages, and I am afraid that there are some people elsewhere who think that it is much nicer to treat the acute sufferers, who quickly respond to treatment, in preference to these poor creatures.¹

With their increased debility and disfiguration, there was more humanitarian and spiritual benefit to the care of those advanced leprosy patients who supposedly suffered more than any other. In 1936, half of the patients at Ongino and Lake Bunyonyi evidenced disability, and in 1933, the majority of patients at Nyenga were not physically capable of cultivating their own food.²

In a talk that Mother Kevin gave to a group of nurses in Europe in the 1930s, she listed a number of the afflictions most common to leprosy patients at Nyenga and Buluba. In 'nerve cases', the patient's nerves would sometimes become thicker and more tender. This could result in 'drop-foot', which gave the patient a 'peculiar walk'. Sometimes an inflammation of the nerves in the arm would bring about 'Maingriff', in which the hand assumed a 'claw-like appearance', with the fingers becoming rigid and closed. Early nerve cases often lost a slight sense of touch, and the missionaries monitored this loss of sensation with the soft end of a feather. As the disease advanced, loss of sensation increased, and they used the sharp end of the feather for sensation tests. Loss of sensation in the hands and feet led to frequent injuries; Mother Kevin complained particularly of the tendency of leprosy patients to burn themselves, especially by grabbing hot utensils. These wounds 'are very painful, as the leper is not aware of the burning till considerable damage has been done, and it

¹ R. Langley, 'Account of Answered Prayer', *Ruanda Notes*, 43 (January 1933), 11-2.

² M. Laing, 'Children's Leper Home', *Mission Hospital*, 40.464 (September 1936), 248; KDA, Medical 1930-39, Bunyonyi Annual Report, 1936; Bishop's House, Jinja, Uganda, Nyenga Annual Report 1933.

reaches the spot where sensation is unimpaired'. Ulcers and sores appeared even more frequently than wounds. In each patient, leprosy was liable to affect different nerves, which would in turn diminish blood supply to certain parts of the body. The 'poorly nourished skin is easily broken, and slow to heal. Any undue pressure brings a sore at once', similar to bed sores. This particular symptom had a very real affect on the lives of advanced leprosy sufferers:

This is a difficulty with regard to cultivation being done by advanced cases, as wherever they grasp the hoe, large spreading ulcers form, and only a Sister in a Leprosy Dispensary knows the amount of time and bandages it takes every day to bind these up before or after hoeing or any kind of manual work. It also requires no little ingenuity to bandage the half fingers etc., often grown into all kinds of shapes. From this same cause we find necrosis of bone often extending to an entire finger, and the sufferer gets no relief until it is amputated.

Toes could be lost in the same way, through injuries and damage done to over-sensitive flesh, which healed slowly and became easily infected. In fact, many of the fingers, toes, and limbs lost by leprosy patients in Uganda's settlements were taken through amputation, in order to prevent even further damage to the patient.³ Some of the other symptoms of leprosy that Uganda's missionaries recounted as physically affecting their patients were blindness; tracheotomies; facial tremors, including the inability to move the eyelids; and damage to the vocal cords, which hoarsened and corroded speech. These kinds of symptoms attended only a minority of all leprosy cases, but there was a preponderance of these advanced, debilitated leprosy cases in Uganda's leprosy settlements, and they sometimes required extensive care and assistance.

While good nutrition, hygiene, and palliative medical care were able to alleviate the worst symptoms of many leprosy patients, the absence of a truly effective biomedical treatment for leprosy in the 1930s and 1940s meant that some leprosy patients deteriorated in condition *after* entering the settlement. At Lake Bunyonyi, the most frequent impetus for

³ St. Francis Hospital, Nyenga, Uganda (Nyenga Hospital), Mother Kevin speech transcript, late 1930s.

replacing medical orderlies was their gradual physical deterioration: 'Every one of the four senior orderlies who came over to the island in December, 1930, has been obliged to give up work here owing to the disease gradually becoming worse'.⁴ At Kumi, the missionaries lamented that 'lack of continuity' engendered by a school where all students and teachers were suffering from leprosy.⁵ Schooling was disrupted by the need of children and their teachers to attend the dispensary regularly for dressings and injections, and by the frequent illnesses of those teachers whose physical condition was not so good. At Lake Bunyonyi, children with infectious leprosy were only permitted to attend school for two hours a day, as schooling combined with limited cultivation was deemed the extent of their physical capability.⁶

Yet disability did not necessarily mean complete physical incapacitation. Very few leprosy patients allowed themselves to be helpless; each hospital had wards where the most advanced, 'crippled' patients lived, but these wards never had more than 20 beds.⁷ Of the 400 leprosy patients cultivating at Bunyonyi in 1936, 100 were partially cultivating, which meant that their bodies were debilitated enough to prevent them from being entirely self-supporting.⁸ For example:

Mary is a tiny old woman, with only the meanest remains of hand and feet, blind in one eye and the whole of her face distorted from the ravages of this terrible disease...Though she has to hold her hoe with her forearms because her hands have gone, she still believes in cultivating her own plot; but it is difficult for the old lady to gather in her own harvest. Our observer was several fields away when she saw Mary gathering her millet. She broke off each head with her teeth; and as she finished each row, she stopped to wipe the blood from her mouth and to see 'Tukutendereza Yesu' (Precious Saviour, Thou has saved me.) Although it was such hard work, she was perfectly happy!⁹

⁴ R. Langley, 'Report of the Leper Work, Bunyonyi', *Mission Hospital*, 479 (December 1937), 317.

⁵ Birmingham, CMS/G3/AL Ailsa Pank 1951.

⁶ G. Mash, 'News of the Leper Children', *Ruanda Notes*, 66 (November 1938), 12.

⁷ For a more in-depth discussion of debility, see J. Livingston, *Debility and the Moral Imagination in Botswana* (Bloomington, 2005).

⁸ KDA, Medical 1930-39, Bunyonyi Annual Report, 1936.

⁹ Birmingham, CMS/G3/AL Janet Metcalf 1951.

This excerpt is part of a larger anecdote that CMS Nurse Metcalf intended as an example of the inspiration that Christ provided for leprosy patients, and is possibly an exaggeration.

Nevertheless, it demonstrates that even disabled leprosy patients were able to support themselves to a certain extent. Another example of the types of disability that leprosy patients could overcome is in one of Bunyonyi's teachers:

Yonasani is the senior church teacher on the infectious side of the Island. He is a very bad nodular (infectious) case, and has had many very bad attacks of the dread lepra fever. He is blind in one eye, and the other eye seemed doomed, when in answer to prayer last year, the Lord prevented the leprosy infiltration spreading beyond the upper half of his left eye, so that he kept the lower half of his field of vision, which is the most important part. One Sunday morning...Yonasani was carried into the hospital in a desparate [sic] state, almost pulseless....In five days' time he was sitting up, and in a fortnight was out of hospital. Today he is back at his work, and very often he reads the lessons in church on Sunday.¹⁰

Much of the rhetoric about leprosy in the colonial world painted the leprosy patient as a victim whose identity was subsumed by the disease, but in reality most of Uganda's leprosy patients were no passive, helpless victims to the ravages of leprosy.¹¹

Patient Experiences of and Attitudes towards Medicine in the Settlement

Until sulphone drugs began to be trialled at Uganda's leprosy settlements between 1948 and 1950, biomedical care for leprosy patients comprised primarily weekly or twice weekly injections of hydnocarpus or chaulmoogra oil, and the regular dressing of ulcers and sores. Dressings were the most frequent and time intensive form of medical care; at times, patients had their bandages changed as often as every two hours in order to avoid the amputation of a limb.¹² It was from these wounds that the terrible smell associated with leprosy emanated, but if they were dressed regularly, the smell was very limited, and not a cause of frequent comment by the missionaries who worked at the settlements. While dressings were provided as palliative care, most doctors believed that the injections would

¹⁰ Birmingham, CMS/G3/AL Janet Metcalf 1948.

¹¹ N. Waxler, 'Learning to be a Leper: A Case Study in the Social Construction of Illness', in E. Mishler et al (eds.), *Social Contexts of Health, Illness, and Patient Care* (Cambridge, 1981), 169-94.

¹² R. Langley, 'Takes a Bit of Her Holiday to Tell Us of Her Work', *Ruanda Notes*, 56 (April 1936), 21.

actively treat and diminish the symptoms of leprosy. A nurse at Lake Bunyonyi described the injections so:

The treatment consists of various types of injections, the most successful ones being intradermal injections of chaulmoogra oil. To get the needle actually into the skin, and not below it, and to force in the heavy oil, is a job needing skill, and also much strength in the fingers. The treatment is very painful, and it is wonderful how good the majority of the patients are, when you think that at the end of a course each one will be having as many as twenty injections at one sitting. Response to treatment is slow, usually taking several years before a patient can be discharged symptom-free: but all the time we can usually see improvement in those on the intra-dermal injections.

An injection was made into each part of the skin visibly affected by leprosy, even on the face, and as you could imagine from this description, all patients found these injections painful.

The pain was not limited to the duration of the injections, but endured afterwards as well: 'A few injections are not very painful, but I know from experience when one is repeatedly being injected the pain is fairly acute, and has many after effects because of the bruised body tissues'.¹³ The injections regularly reduced children to tears, or, for example, the 'only way to stand these horrid injections, each one worse than the last, was to pretend you didn't care a pin about them and make as much noise as possible – which is what they all did'.¹⁴

The efficacy of these injections was doubted by many leprosy patients, and even called into question by some of the missionaries. As CMS Dr. Sharp wrote of improvements in many leprosy patients' health, 'How far these good results have been due to the hydnocarpus oil injections, and how far to the excellent general conditions prevailing in the colony is rather a controversial issue'.¹⁵ Nurse Langley reported that:

As Leprosy takes so long even for the slightest improvement to be really noticed after some months the lepers become very impatient & in consequence refuse their treatment and it is with the utmost difficulties they are persuaded to receive injections. Even the children and tiny babies are encouraged not to attend and backed up by their parents.¹⁶

¹³ Langley, 'Takes a Bit of Her Holiday to Tell Us of Her Work', 20.

¹⁴ 'A Leper Boy', *Day Star in Africa*, 15 (October 1949), 18.

¹⁵ L. Sharp, 'Lake Bunyonyi Leper Colony', *Mission Hospital*, 38.442 (November 1934), 286.

¹⁶ Birmingham, CMS/G3/AL Rosa Langley 1935.

Mother Kevin added that ‘most of the drugs used are a two-edged sword, and may have unfortunate results in the hands of the inexperienced. The gloomy outlook presented by some as to the prognosis of leprosy may be partly due to these failures’.¹⁷ It is no wonder, then, that patients doubted the efficacy of these injections if they had to wait years to see substantial signs of improvement, and no wonder that ‘they get very tired of injections after the first few weeks and unless almost forced they have no wish to continue them’, if they were so painful.¹⁸ As one former leprosy patient noted, ‘Lepers got tired and left simply because they had taken so long a time on medicine but with no greater improvement’, and as Nurse Langley agreed:¹⁹

It is a very weary existence for them, because they feel that they ought to be cured within a few months, and don’t realise that it takes years before they are really symptom free, and then there is always the question of a permanent cure. Naturally they begin to get wearied and long for the time to come for them to be really well.²⁰

The injections painful enough to become locally notorious. One former leprosy patient recalled that he had delayed in entering Buluba settlement for a long time because ‘people would utter frightening words that people suffering from that sickness are injected with big needles. This would definitely scare us to go to hospital’.²¹

Although most leprosy patients used various traditional medicines when they first developed the symptoms of leprosy, there is a conspicuous absence of evidence that traditional medicine was ever used by patients *in* the settlements. This is reputedly because the missionaries would not allow it, and because the traditional medicine had already failed, or else the patients would not have entered the settlement. A number of leprosy patients interviewed went so far as to suggest that missionaries were the only ones with medicine that

¹⁷ Nyenga Hospital, Mother Kevin speech transcript, late 1930s.

¹⁸ Birmingham, CMS/G3/AL Rosa Langley 1936.

¹⁹ Interview with Yoana, 28 April 2010 (Buluba, 1947, age 4).

²⁰ Langley, ‘Account of Answered Prayer’, 12.

²¹ Interview with Silve, 22 April 2010 (Buluba, 1955, child).

worked for leprosy.²² This begs the question of what medicine patients would choose to use for ailments other than leprosy while living in the leprosy settlements. The answer is unknown, but leprosy patients were just as prone to secondary ailments as other men and women, and were far more likely to die from such afflictions than from leprosy itself. Out of the 704 leprosy patients at Lake Bunyonyi in 1948, Dr. Innes recorded yaws (284), mossy foot (15), elephantiasis (12), gynecomastia (8).²³ At Nyenga, he recorded the chief intercurrent diseases as syphilis, malaria, dysentery, and intestinal parasites, and at Buluba, in addition to these diseases, scabies, filariasis, trachoma, and sleeping sickness were also present.²⁴ Of 447 leprosy patients resident at Buluba in 1950, the settlement's doctor at Buluba recorded ancylostomiasis (222), onchocerciasis, or river blindness (200), scabies (180), tinea versicolor (170), yaws (60), amoebic dysentery (7), tuberculosis (3), filariasis (3), venereal disease (2), and a moderate incidence of malaria.²⁵

When leprosy patients did adhere to the biomedical regimen of leprosy treatment in spite of its painfulness and lack of visible effectiveness, the missionaries ascribed it to the intelligence or spiritual awakening of these patients. When Dr. Wiggins started out-patient leprosy treatment in Teso, he wrote that the Iteso 'have not sufficient intelligence to grasp the fact that regular attendance is essential', whereas 'a few Baganda and Nubians who have more intelligence than the Teso, and who have come from a distance for their treatment, state that they feel much improvement and their regularity in attending confirms this'.²⁶ At Lake Bunyonyi, when the weekly adult attendance for injections rose from 40 to 400 in 1936, Miss Langley explained that 'although we are not making their injections compulsory after they have finished one course, the effect of the spiritual awakening is bringing them for their

²² Interview with Yoana and Vincent, 15 August 2011 (Buluba 1947/1944, age 4/18); Interview with Pulekeria, 26 July 2010 (Nyenga, 1949, age 9); Interview with Lawrence, 6 July 2010 (Kumi, 1959, age 19).

²³ UGA, J6/25I, Innes Report 5.

²⁴ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3.

²⁵ RCA, Buluba Annual Report, 1950.

²⁶ 'Editorial Notes', *Mission Hospital*, 385 (February 1930), 31; Leprosy Mission, 118/16, Ngora Leper Mission Annual Report, 1928.

injections’.²⁷ It is certainly possible that increased faith in Christianity would be linked to an increased faith in biomedicine, for Ugandan leprosy patients had no reason to believe in one more than the other, or even to separate the two. It is also possible that a prior familiarity with biomedicine, which would have been more likely among Bagandans, would encourage adherence to a biomedical regimen for leprosy. But for many of the leprosy patients who accepted biomedical treatment for leprosy, that treatment was a matter of hope and faith, not the product of a growing conviction in biomedicine, as the missionaries oft stated.²⁸ Asked why some leprosy patients chose to leave the settlement without permission, one long time Buluba resident said that ‘lepers got tired and left simply because they had taken so long a time on medicine but with no greater improvement. So they opted to leave since they had lost hope about getting completely cured from leprosy’.²⁹ Another added that: ‘Those who adhered to the treatment got cured and went away while those who easily gave up escaped and ran away’.³⁰ One of the earliest child patients at Kumi said that ‘Indeed some people got cured. We had to have hope’.³¹ Thus adherence to biomedical leprosy treatment in the 1930s and 1940s required hope, faith, and perseverance.

The Emotional Experience of Leprosy

Although the dominant mission narrative concerning the emotional life of leprosy patients in Uganda focused on how these men, women, and children bore the pain and suffering that accompanied leprosy with stoicism, happiness, and faith in God, patient interviews and the occasional mission letter reflect a much more emotionally mixed and bitter experience for leprosy sufferers. Some leprosy patients, especially those who came from areas where leprosy was stigmatised, came to the settlement feeling shamed and defensive

²⁷ Birmingham, CMS/G3/AL Rosa Langley 1936.

²⁸ Iliffe, *The African Poor*, 219; Birmingham, CMS/G3/AL Marjorie Atkinson 1931.

²⁹ Interview with Yoana, 28 April 2010 (Buluba, 1947, age 4).

³⁰ Interview with Yoana and Vincent, 15 August 2011 (Buluba, 1947/1944, age 4/18).

³¹ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

about their condition. As a Buluba missionary wrote, 'Being for so long treated as 'outcasts', and even regarding themselves as such, they are generally inclined to be introverted, suspicious, over-sensitive and, sometimes, aggressive'.³² Some leprosy sufferers felt great despair when they realised they had contracted leprosy, believing that the disease spelled their untimely death, and even contemplated suicide.³³ Others felt a fear of leprosy's potential debilitating symptoms, and of the social stigmatisation they might face.³⁴

While some leprosy patients felt despair, dread, or shame, these sentiments were by no means universally held by all leprosy sufferers. Many of the leprosy patients interviewed who contracted leprosy as children recalled being too young and carefree to understand the potential implications of being diagnosed with leprosy.³⁵ Even more of the former leprosy patients expressed a sense of resignation or acceptance of the disease, with such comments as 'How else could I have taken it, it was God's plan!' and 'What else could I do, could I change the fact?'³⁶ After entering the settlement, many remembered feeling much happier, as the missionaries had claimed. None, however, expressed this happiness as a result of their new relationship with God. Rather, they were happy because they were well provided for; they did not feel isolated because they were living with many others suffering from disease; or they had a hope of being cured of the disease. This happiness was not remembered as complete: child leprosy patients especially commented on how they missed their families, and others commented on their resentment or sadness over the disinterest or mistreatment they faced from friends and family who did not live in the settlements.

³² St. Francis Hospital, Buluba, Uganda (Buluba Hospital), Buluba: 50 Years (1984), 6.

³³ Interview with Oluka, 6 July 2010 (Kumi, 1949, age 19); Interview with Paulo, 7 July 2010 (Kumi, 1950s, young boy); Interview with Samson, 7 July 2010 (Kumi, 1951, age 21); Interview with Tom, 22 April 2010 (Buluba, 1954, age 6); Interview with Silve, 22 April 2010 (Buluba, 1955, child).

³⁴ Interview with Lawrence, 6 July 2010 (Kumi, 1959, age 19); Interview with Vincent, 11 August 2011 (Kigezi, 1970s, age 25).

³⁵ Interview with Tom, 22 April 2010 (Buluba 1954); Interview with Margaret, 26 July 2010 (Nyenga, 1949, age 10).

³⁶ Interview with Tom, 22 April 2010 (Buluba 1954, age 6); Interview with Demetria, 28 April 2010 (Buluba, 1961, age 30).

Some leprosy patients, especially that minority who experienced the advanced stages of leprosy, struggled between pain and suffering on the one hand, and hope and faith on the other. Contrary to the professions of Uganda's leprosy missionaries, hope was not always a solace to the leprosy patient. In interviews, a small minority of leprosy patients expressed bitterness and resentment over the debility that leprosy had wrought upon their bodies. In one case, an elderly woman blamed the missionaries for bringing her to the settlement and then failing to halt the progression of leprosy. After all, when she had entered Nyenga in 1944, against her will, she had not been blind.³⁷ As one old man observed, leprosy could be 'a very bitter experience. People lost toes, limbs, fingers, rolling tears on their eyes every other time'.³⁸ Sometimes when a leprosy patient died, the missionaries would express their gladness that in death, they would 'see the end of their awful suffering'.³⁹ A CMS missionary wrote of a leprosy patient, Shadrach, who had come very near to death. 'One day, finding his temperature subsiding, I tried to cheer him with the thought that he was getting better. "Oh, Sir," he said "talk not to me of getting better, but tell me rather of God and heaven, where I am soon going.'⁴⁰ This was a frequently expressed sentiment in missionary accounts, though it is borne out in only one interview, with the most disabled of the Catholic leprosy patients, who said that she was 'only seeing good things so high above the sky'.⁴¹

Other leprosy patients felt more positive and hopeful in the face of disability and pain. The missionaries may have believed that Satan kept busy trying to get leprosy patients down through 'physical disabilities and sufferings', but according to the missionaries, he rarely succeeded, because the patients tried so hard to be cheerful and hopeful of their futures.⁴² One missionary wrote that, 'I always feel the work amongst the adult lepers is more difficult.

³⁷ Interview with Doreen, 30 April 2010 (Nyenga/Buluba 1944, age 18).

³⁸ Interview with David Livingstone Oitamong, 7 July 2010.

³⁹ Birmingham, CMS/G3/AL Beatrice Martin 1934.

⁴⁰ A.C.S. Smith, 'Letter', *Ruanda Notes*, 33 (July 1930), 7.

⁴¹ Interview with Doreen, 30 April 2010 (Nyenga/Buluba 1944, age 18).

⁴² 'Lake Bunyonyi Leprosy Settlement', *Ruanda Notes*, 111 (May 1950), 5.

The out-look is really less hopeful, although many results are good. Some of them are so brave, but they need a lot of encouragement'.⁴³ With encouragement and support, many leprosy sufferers came to accept, or at least became resigned to their bodies' disfigurement and debility. One mission doctor reported a 'complacent indifference regarding digits and their uses'.⁴⁴ Certainly leprosy patients received more care and support than any other disabled Ugandans, by virtue of leprosy's special humanitarian and religious place, and the rare leprosy patient expressed gratitude that they had contracted leprosy, because it had brought them economic opportunities that they would not otherwise have had.⁴⁵ Moreover, the staff of Uganda's leprosy settlements made great efforts to support physically disabled leprosy patients in overcoming debility and leading a 'normal' life. Buluba and Kumi were Uganda's first centres for the development of prosthetics and physiotherapy, and even today most of the country's prosthetics are built in these former leprosy hospitals. One former Buluba patient expressed that he used to feel a lot of pain, but since his legs and hands were chopped off, he had learnt to be normal in that state. As a normal human being, he suffered from malaria, but no longer leprosy.⁴⁶ The most disabled of the Anglican leprosy patients interviewed did not look to Heaven for the relief of her suffering, but rather said she had always believed that 'with God I will *live*'.⁴⁷

Patient Attitudes to Evangelisation

Christianity was a perpetual part of life for patients in Uganda's leprosy settlements, with twice-daily religious services, preaching during medical treatment, weekly home visits, and regular classes and meetings. At the end of 1947, leprologist Dr. Innes estimated that at Nyenga, 40 percent were Catholic, 15 to 20 percent were Protestant, 15 to 20 percent were

⁴³ Leprosy Mission, 119/4, Letter from M. Laing, 9 March 1940.

⁴⁴ RCA, Buluba Annual Report, 1950.

⁴⁵ Birmingham, CMS/G3/AL Esther Sharp 1946.

⁴⁶ Interview with Vincent, 28 April 2010 (Buluba, 1944, age 18).

⁴⁷ Emphasis mine, Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

Muslim, and the remaining 20 to 30 percent were pagan.⁴⁸ At Buluba, 50 percent were Catholic and the majority of the remainder were pagan.⁴⁹ At Lake Bunyonyi, about a third of the patients were Protestant, and the majority of the rest pagan.⁵⁰ These estimates, which are the only overall counts of the settlement's religious compositions available, do not include those leprosy patients who were reading for baptism, which could be a significant additional number.⁵¹

In order to convert to Christianity, leprosy patients had to go through several different steps. At the CMS Lake Bunyonyi settlement, the leprosy patients first joined a reading class. Before they could be accepted for the baptism class 'they must prove that their lives really are changed by the Power of Christ Jesus', and in order to be passed for baptism they had to be able to read Luke and Mark's gospels for themselves, pass an examination, and continue to 'have given real evidence of conversion or changed hearts and proved by their lives that they have accepted Christ as their Saviour', as the missionaries did not 'encourage Baptism either for adults or children until we are assured of their sincerity'.⁵² After baptism they would enter confirmation class; about two-thirds of the leprosy patients who were baptised went on to become communicants, or full members of the Anglican Church, through confirmation. Patients at Kumi and Ongino went through a similar process, and if they displayed 'bad behaviour' they would be put on probation and prohibited from reading with the remainder of their class until they had made amends. Such reprimands were 'a good object lesson to the others, and emphasised the point slowly grudgingly by the African, that a

⁴⁸ UGA, J6/25I, Innes Report 1.

⁴⁹ UGA, J6/25I, Innes Report 3.

⁵⁰ UGA, J6/25I, Innes Report 5.

⁵¹ Birmingham, CMS/G3/AL Rosa Langley 1935.

⁵² Birmingham, CMS/G3/AL Rosa Langley 1935.

verbal attachment to acquiescence of the principles of the Christian Group is not what is required'.⁵³

The FMSA missionaries at Nyenga and Buluba wrote much less frequently of the process by which leprosy patients attained conversion, except to say that patients in extremely poor health, who had not long to live, could be baptised without attending the requisite courses.⁵⁴ The Catholic settlements did have groups of patients reading for baptism and then for confirmation, but achieving literacy was not a prerequisite for baptism. Only 20 percent of the leprosy patients at Nyenga were literate, which would at most have amounted to half of all baptised Christians, and only 15 percent at Buluba were literate, which amounted to less than a third of baptised Christians.⁵⁵ According to the name changes recorded in Buluba's patient records, most baptisms occurred within about a year and a half of the patient's entry, which suggests that most leprosy patients reading for baptism were accepted within that time period.

The missionaries believed that leprosy patients were specially called to Christianity because their suffering gave them the possibility of a special relationship with God, and given that suffering, Christianity was the only thing that could offer them hope and happiness. As one CMS missionary wrote:

We have had a lot of new lepers this year and most of them are in a very bad state when they come to us, practically all are heathen and have no hope in this life but we have the joy of telling them the Gospel stories and very soon they begin to change and realize that they have a Friend Who really loves them.⁵⁶

Moreover, 'The acceptance of the Gospel, with its assurance of pardon, and the redeeming experience of the life in Christ, means that for the leper a mental state of such peace and joy

⁵³ Leprosy Mission, 119/4, Letter from A. Downes-Shaw to Anderson, Secretary, Mission to Lepers, 8 June 1934.

⁵⁴ Mother Kevin, 'Mother Kevin's Worldwide Appeal for the Lepers', *The Universe* (19 January 1934).

⁵⁵ UGA, J6/25I, Innes Report 1; UGA, J6/25I, Innes Report 3.

⁵⁶ Birmingham, CMS/G3/AL Grace Mash 1943.

that all specific treatment is enhanced in value'.⁵⁷ However, there is no firsthand evidence from Ugandan leprosy patients to suggest that Christianity acted as a solace or a cure for leprosy. Links between Christianity, healing, and hope were strikingly absent in all leprosy patient interviews, though all but one were Christian. In fact, the only link between Christianity and leprosy came from a few former leprosy patients who said that it was God's wish that they should have leprosy, and therefore they had to accept it.⁵⁸ All expressions of hope and faith in relation to health and happiness referred to biomedicine. Even devout Christians were probably as likely to scoff at the idea of God's power to heal as to believe in it, as demonstrated by an anecdote of the miraculous healing of an advanced leprosy patient at Bunyonyi: 'The people who had carried him all said they had brought him to die, and one of his male relatives, though quite a keen Christian, just laughed when I said the Lord could still heal him'.⁵⁹

In spite of the absence of first-hand evidence confirming the missionaries' descriptions of leprosy patients and their relationship with Christianity, it is possible that some individuals found Christianity to be a source of purpose, comfort, and hope. There are certainly enough anecdotes about individual leprosy patients and their relationships with Christianity. For example:

Last week, Kyeko, who had chosen the very appropriate name of Job, passed to the better world. I went down to the hospital early in the morning to see him and knew that the infection had spread too far for any hope of cure, and I said: "Job, you are going to heaven to see Jesus." He answered with a bright smile and just said "Yes, Jesus."...He passed away at midnight with a real assurance of God's salvation. The next day we had a wonderful little Service around his grave...A few words to the lepers and prayer concluded the Service, but it was the expression on the faces of his friends, those who had been baptized with him; I can never doubt the reality of their faith again. Weak, feeble, faltering children in Him they may be, but may God always give me their faith.⁶⁰

⁵⁷ A.C.S. Smith, 'Leprosy in Kigezi, Uganda Protectorate', *Mission Hospital*, 407 (December 1931), 315.

⁵⁸ Interview with Doreen, 30 April 2010 (Nyenga/Buluba, 1944, age 18); Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9).

⁵⁹ Birmingham, CMS/G3/AL Janet Metcalf 1948.

⁶⁰ Langley, 'News of the Lepers', 17.

Leprosy patients also organised prayer meetings, fellowship groups, and bible study groups of their own accord, and at Lake Bunyonyi some even acted as evangelists for neighbouring communities, on their own initiative and supported by collections from the leprosy patients' church.⁶¹ At the CMS leprosy settlements, patients also saved up the small monies they received as wages so that they could buy Bibles, New Testaments, Catechisms, and hymn books.⁶² A number of Christian leprosy patients asked if they could stay on in the settlements, even when they were physically ready for discharge, because there was no teacher or Christian community in their own village.⁶³

Although there were many apparently keen Christians in the leprosy settlements, leprosy patients were not necessarily choosing to convert to Christianity for the reasons that the missionaries hoped. Just as a child at Lake Bunyonyi answered that the chief benefit obtained by attending school was that 'We are able to see one another', Christian meetings at the settlements were also an occasion for socialising:⁶⁴

The Bible Class for staff at Kumi...recently grew to about 25 in number, from a steady 12 or 15. An interesting controversy arose when it was suggested that 25 was too large a number for our limited accommodation, and indeed for one class at all; perhaps two would be better. There was a strong difference of opinion among the regular members, which ended in some withdrawing from attendance altogether, so that the necessity for dividing the class no longer arose! This formed an interesting commentary on motives for attending such a Class!⁶⁵

The CMS missionaries firmly ascribed successes in evangelisation to other Christians in the settlement. 'To the witness of the Christian lepers and their influence is due, in large measure, the spiritual development in the others'.⁶⁶ Indeed, the missionaries believed that the guidance of Ugandan Christians was the only thing that could persuade recalcitrant leprosy patients to embrace Christianity:

⁶¹ Birmingham, CMS/G3/AL Grace Mash 1948.

⁶² E. Gardner, 'News of the Leper Island', *Ruanda Notes*, 64 (April 1938), 17.

⁶³ Birmingham, CMS/G3/AL E. Gardner 1938.

⁶⁴ R. Langley, 'Letter', *Ruanda Notes*, 60 (April 1937), 15.

⁶⁵ Birmingham, CMS/G3/AL Ailsa Pank 1951.

⁶⁶ "'The Healing of His Seamless Dress": Annual Report Number', *Mission Hospital*, 41.476 (September 1937), 211.

I was very sad to discover that we have still a certain number of people who are refusing to read, which means that they do not wish to become Christians...I am trying to get the keen Christians to realise their responsibility towards these people, because I feel with cases such as these who have every opportunity of hearing, and yet still refuse, the witness of the lives of Christians round them, is the only hope for them.⁶⁷

Some patients may have converted to Christianity because that was what their peers were doing, and they wanted to be a part of the group. Others may have felt compelled to conversion.⁶⁸ Both Catholic and Protestant missionaries claimed that no religious compulsion existed within their settlements, but in interviews several Catholic leprosy patients recounted that prayer services had been mandatory, and that although they were now very happy with their religion, they felt conversion had been a prerequisite to living in the leprosy settlement, especially if they had previously been Anglican.⁶⁹

Furthermore, not all of the leprosy patients who converted to Christianity perceived that conversion in the same light as the missionaries, or even understood the religion in the same way. Although many leprosy patients found the idea of Christianity, and in particular Heaven appealing, learning to read and comprehending a different cosmological framework was at times a slow process, and from the missionaries' perspective, fraught with misunderstandings:

It takes time, love & patience to break down their faith in heathen rites of many years standing and to accept something absolutely new to their ideas of a Deity...Day after day to come to be taught to read and grasp things that are almost beyond their comprehension however simply put. There is one thing though, which they do learn quickly and that is how to love Jesus & to live out his commandment that they should love another.⁷⁰

For some missionaries, evangelisation was about the 'many beliefs that need absolutely driving out of their heads before you can instil the truth', for example such ideas as 'The Angels are all Gods, but there is one chief God who is able to punish them if they don't do

⁶⁷ E. Longley, *Ruanda Notes*, 71 (March 1940), 13.

⁶⁸ Interview with Paulo, 7 July 2010 (Kumi, 1950s, young boy).

⁶⁹ Interview with Margaret, 26 July 2010 (Nyenga, 1949, age 10); Interview with Francis, 27 July 2010 (Nyenga, 1953, age 18).

⁷⁰ Birmingham, CMS/G3/AL Rosa Langley 1932.

what they are told' or 'Satan is a part of God who tries to make men do wicked things so that they will never be turned into little gods'.⁷¹

Leprosy patients were often willing to listen to the preaching offered by missionaries and other Christian residents of the settlement, but not necessarily eager to begin instruction for baptism, with all the expected behavioural changes and monitoring that this entailed: 'They gradually drift in, first to one meeting, and then another, and... change gradually comes over them. They are not untouched by what they hear, but some seem very loath to take the definite step'.⁷² One CMS missionary commented, in the early years of leprosy mission in Teso:

Although a great keenness is shown, one feels if anything, they are too eager, little grasping the very big step they are taking. We invariably receive a welcome on our visits to the people in their homes, and up to a point the native is ready and willing to sing hymns – listen and pray – and yet one rarely sees any desire for change in their lives. Nothing seems to rouse them – very few in this district are out and out Christians, showing the Power of Christ in their lives.⁷³

It is no wonder that some were reluctant to take definite steps towards conversion to Christianity, given that as in-patients they were almost perpetually under the eyes of the settlements' Christian staff, which meant that their lifestyle was likely to be more closely scrutinised than many other Ugandan converts. Instead, many leprosy patients seem to have regarded Christianity with desultory interest, or as a social activity. For example, attendance at prayer services and Sunday mass could be very dependent upon the season; if there was no harvest to bring in, patients were far more likely to attend religious events.⁷⁴ Some leprosy patients converted to Christianity, but afterwards did not choose to live the Christian lifestyle that the missionaries expected of them. A newly appointed mission doctor at Kumi went so far as to say that 'the majority of Christians are nominal only', and Catholic and Protestant missionaries alike complained of the 'sad moral lapses among the members of this infant

⁷¹ Langley, 'News of the Lepers', 17.

⁷² E. Longley, 'Tells of Christmas on the Leper Island', *Ruanda Notes*, 67 (February 1939), 25.

⁷³ Birmingham, CMS/G3/AL Marjorie Atkinson 1931.

⁷⁴ Birmingham, CMS/G3/AL E. Gardner 1938.

Church'.⁷⁵ Even the most devout of Christians would sometimes 'fall away...get terribly slack and think if they just go to church on Sundays it is enough'.⁷⁶ After a few years, they might change again and come 'back to the foot of the cross'.⁷⁷ Christianity suffused life in the leprosy settlements, but individual leprosy patients perceived and reacted to the religion in different ways, some finding support and joy and others eschewing the drastic lifestyle modifications that it required.

Negotiating Life in the Leprosy Settlement

Although Uganda's leprosy missionaries had ideals for the creation of an alternate, civilised world within leprosy settlements, in reality these missionaries were very few, and they had to negotiate with patients in order to keep the settlements full and functioning.

One of the issues that involved extensive negotiation between missionaries and leprosy patients was that of separating 'untainted' babies from their infectious parents, and the gradual shift in child separation policies at Lake Bunyonyi furnish an example of the effects of negotiation over the course of years. The island's missionaries opened a crèche for untainted children in 1934, housing 18 apparently healthy children of infectious parents. Within ten months, however, 14 of these children developed symptoms of leprosy, which the missionaries blamed on the parents' unwillingness to part with their children early enough; all of the children were five years of age or older.⁷⁸ With so many children contracting leprosy from their parents, even under the age of twelve months, in 1936:

Parents were interviewed, pleaded with, mother's [sic] comforted, father's threatened, and eventually the Lukiko beseeched to help us use a little gentle force...and today 13 little lambs of round about 2 years are sitting happily playing with their dolls and toys in the Untainted Children's Home with the chance of being spared the suffering of their parents...It is a fallacy to say that African parents do not care for their children. Had you seen the little mother who clung to me sobbing this week with the tears

⁷⁵ Birmingham, CMS/G3/A10/m1A, Letter from Dr. Wheate to Hooper, 9 June 1949; 'Annual Report Number', *Mission Hospital*, 32.367 (August 1928), 179.

⁷⁶ Birmingham, CMS/G3/AL Grace Mash 1943.

⁷⁷ B. Martin, 'Carries on on the Leper Island', *Ruanda Notes*, 46 (October 1933), 16.

⁷⁸ Birmingham, CMS/G3/AL Rosa Langley 1935.

streaming down her face, in agony because her little one was gone from her, you would know and feel as I knew and felt, whether they care or not...Now my scheme is as soon as an untainted child reaches 2 yrs to just take it and put it in without any fuss. It is always creating the precedent in these cases that causes the trouble.⁷⁹

With only ten untainted children above the age of weaning living with infectious parents, the missionaries were able to fight this first battle with a smaller group of parents, hoping then to set a precedent for the separation of children at the age of weaning. They could not officially use compulsion in this endeavour, so instead they influenced the Lukiko, or settlement council, to assist them in negotiating for the removal of children, not at five years, but at two years. Certainly some of these parents felt compelled to part with their children against their will, for reasons they did not agree with, because when four of these toddlers showed symptoms of leprosy over the next year, Miss Langley reported that the ‘mothers clapped their hands with glee, because they would get to keep their babies’.⁸⁰

Negotiations over child separation continued for the next decade, as missionaries tried to convince parents to part with their children at an increasingly young age. These negotiations included the duration, frequency, and nature of the parents’ contact with their children, as well as the apparent quality of the children’s care. The missionaries were conscious that they needed to be seen to take good care of the children, for the parents were watching, and could withdraw their children if they felt justified. Nurse Langley wrote that she was ‘praying that nothing happens to alienate parents, such as children taking ill... If things go smoothly now we shall automatically be able to take them at two years of age and perhaps in time to come even younger. It is all a matter of gaining their trust and confidence first’.⁸¹ Although struggles over the separation of each child continued, with a precedent set and the Lukiko’s authority to call upon, the missionaries managed to make child separation a rule. According to the missionaries, parents gradually came to understand the value and

⁷⁹ Birmingham, CMS/G3/AL Rosa Langley 1936.

⁸⁰ R. Langley, ‘Last Letter before Leaving’, *Ruanda Notes*, 62 (October 1937), 24.

⁸¹ R. Langley, ‘Diary Gives a Vivid Account of Life on the Leper Island’, *Ruanda Notes*, 58 (October 1936), 21.

importance of this separation. 'A few weeks before Miss Longley had taken another of their children for the Creche after a lot of difficulty, but now the father told me he realises we were trying to do our best for his children and they were trusting God'.⁸²

It was not until 1946 that the island's missionaries were finally able to succeed in their long desired goal of separating all children from infectious parents at birth. Given that this step took place ten years after the age was decreased to two years, it must have taken extensive negotiation, and even with this change, the missionaries had to make considerable allowance for mothers, in order for the scheme to function. For the first six months of each baby's life, the mother could come to the hospital where the babies were kept, and after washing their breasts, hands, and arms, and putting on a special, protective white gown, they could breastfeed their children under supervision. At six months, the children were gradually weaned and transferred to the crèche, after which point their parents interacted with them less frequently.⁸³ In addition, the missionaries had to build an outside enclosure near the babies' ward in the hospital, so that parents could at least come and look at their children, and see that they were well, as opposed to the crèche isolated atop a hill where children over two years of age lived, and were paraded down only once a month to see their families, though parents could make special visits up the hill to see their children.⁸⁴

It was not then until 1950 that the missionaries reported most parents as being reconciled to the separation from their children: 'Most of the mothers have lost their prejudice about their children going to the Home; naturally they feel the separation terribly but now they trust Damali, the African matron'.⁸⁵ It took 15 years of gradual change and negotiation between missionaries, parents, and leprosy patients in positions of authority, in order for the missionaries to achieve their initial goal of separating babies from their

⁸² G. Mash, 'Tells of Progress and Blessing Among the Lepers', *Ruanda Notes*, 70 (November 1939), 18. Miss Longley was another CMS missionary who followed Miss Langley's tenure.

⁸³ Birmingham, CMS/G3/AL Janet Metcalf 1946.

⁸⁴ J. Metcalf, "'Meet Joy"—and Pray for Her', *Ruanda Notes*, 101 (August 1948), 5.

⁸⁵ 'Annual Report, 1949-50', *Ruanda Notes*, 108 (1950), 7.

infectious parents at birth. In achieving this goal, they could not simply institute compulsory separation, but rather had to slowly set a precedent and negotiate a policy of parent-child interaction after separation, that was palatable enough to parents to induce them to relinquish care of their children.

Lake Bunyonyi's Lukiko, established in 1934, acted as intermediary in negotiating many matters between leprosy patients and missionaries. The members sat every other week in judgment of the various disputes that arose in the course of life on the island, such as small thefts, spousal abuse, patients shirking their work, whether husbands had paid properly for their wives, and whether certain individuals should be allowed to marry.⁸⁶ Although the Lukiko members were chosen as Christian and responsible leprosy patients, they had their own agenda in handling these matters:

Our Council...will never pass a motion or do anything that is going to hurt themselves in anyway. They are quite willing to pass judgement on culprits as long as it is'nt [sic] a personal friend, but then the trouble commences. The actual facts are that the island Chief (who often needs his hands or arms holding up) the Head Hospital Orderly (untainted) and myself have to stand together in prayer and sway the Council to our way of thinking. Perhaps in a few years time things will be different and they will be strong enough to do the right thing themselves irrespective of the cost.⁸⁷

Even though the Lukiko was not entirely free of the missionaries' influence, its existence allowed at least some of the island's leprosy patients the power to negotiate.

Compulsory biomedical treatment was one of the issues that provoked tension between missionaries and leprosy patients at Lake Bunyonyi. In 1936, only 40 of the island's 500 leprosy patients were regularly attending for biomedical injections, as the missionaries were unable to use compulsion in order to bring adult leprosy patients for a weekly treatment. Even if the government would have permitted the use of such compulsion, the settlement simply did not have enough staff for the compulsory medical treatment of 350 men and women. In 1936 there were two full-time women missionaries, one policeman, one headman,

⁸⁶ Birmingham, CMS/G3/AL Grace Mash 1946.

⁸⁷ Birmingham, CMS/G3/AL Rosa Langley 1936.

three ‘untainted’ hospital staff, three ‘tainted’ medical orderlies, and three ‘tainted’ nurses.⁸⁸

Thirteen staffers, excepting the teachers and child caretakers, were hardly enough to stand against 310 people who did not wish to attend regularly for a rather painful biomedical treatment. On the other hand, the missionaries saw an opportunity for the compulsory medical treatment of children, who could not object as powerfully or effectively as their adult counterparts. School attendance had already been compulsory since 1933; teachers matched their students against a daily attendance roster, and if a student was absent without appropriate justification, the island policeman would find them and take them to class.⁸⁹

With all the settlement’s children already in school, the lady missionaries decided to give the children injections in their classrooms, rather than the hospital, effectively ensuring compulsory treatment. However:

This was one of the big fights with the Native Council. They did not wish their children to be injected and therefore would not help to make the injections compulsory or punishment for the children staying away. However with a few of us standing firm we were able to over-rule their objections.⁹⁰

Although the Lukiko did not win this particular argument, it is significant that it occurred in the first place. At Kumi, where child leprosy patients lived separately from the adults who could have advocated on their behalf, regular medical treatment was absolutely compulsory. At Lake Bunyonyi, on the other hand, patients had at least enough of a voice and a role to play that they could argue on behalf the children, and create difficulties for the missionaries.

Bunyonyi’s missionaries wrote rarely enough about the fights that they had with the Lukiko, and almost never about the fights that they lost. However, they were on occasion willing to admit that they had to choose their actions very carefully in order to avoid alienating patients. Controlling patients, in their words, sometimes required ‘very careful handling’, and at times they even called external authorities to manage internal settlement

⁸⁸ Birmingham, CMS/G3/AL Rosa Langley 1936.

⁸⁹ M. Forbes, ‘School Work among the Lepers’, *Ruanda Notes*, 46 (October 1933), 18.

⁹⁰ Birmingham, CMS/G3/AL Rosa Langley 1936.

disputes. One example of this was when, in 1937, Miss Langley decided she did not wish there to be any dogs on the island. She wrote to the DC in hopes of solving this problem:

I have been wondering if you could help me in anyway [sic] about the dogs on the Island. I have not the power to banish them as I would like to. The leading man on the Leper Lukiko unfortunately has EIGHT. Every-time it is brought up he backed by the others turn it down. If we could say 'it is the word of Mwami D.C. no dogs on the island because of the illness' it would help, but I cannot say this unless it is really so. I do realise their love for their dogs, but they are so dirty and unhygienic and even have to be chased at times from the Hospital.⁹¹

The DC complied forthwith, consulting the DMO and sending a letter to the local chief dictating that all dogs be removed from the island within one month, because they were unhygienic. He also sent a copy of this letter to Miss Langley, so that she could show it to the Lukiko if they should 'become truculent when you...confront them with it'.⁹² This evidence indicates that the missionaries at Bunyonyi did not have absolute power over the settlement's patients. Evidently, they chose their battles very carefully, pitching large fights about medical issues such as separation of children from infectious parents and compulsory medical treatment, and then employing a variety of strategies to try to successfully negotiate with patients.

Taking Advantage of the Settlements

Many leprosy patients found small ways to take advantage of the opportunities that life in a leprosy settlement offered, outside the paths of progress proscribed by the missionaries. The most frequently reported instance of such attempts to take advantage was what missionaries labelled as 'laziness', but which from a new patient's perspectives was probably an attempt to see how much material support they could wrangle from the missionaries. At Lake Bunyonyi, the missionaries provided new patients with food for their first five months at the settlement, while they grew their own food. But:

⁹¹ KDA, Medical 1930-39, Letter from Langley to DC Kigezi Jenkins, 26 April 1937.

⁹² KDA, Medical 1930-39, Letter from DC Kigezi Jenkins to Langley, 29 April 1937.

To anyone who knows the African they would realise that they would much prefer to go on being supported forever and never lift a hoe. One therefore has to check up the cultivation of newcomers each week. If this is not done, we find at the end of their 5 months, they have not yet even begun their cultivation patches.⁹³

A solution to this problem was a discussion with each patient, on entry, requiring that they agree to the settlement's work regulations.

The missionaries also wrote with amusement of small incidents where patients took advantage of the amenities provided by the settlement in order to earn some money. Miss Laing recounted one incident at Ongino:

It is good to be able to see the funny side of things sometimes, for many amusing things happen. A leper came to me one day and said: "Sister, will you give me a rat trap?" I replied: "I will lend you one, and please return it in a week's time." But two weeks passed and I forgot all about it. One Sunday morning, after taking a service for the adults, another leper said: "Sister, will you give me a rat trap?" "Oh," I replied, "that reminds me that I have already lent one to Isaka; ask him for it." "But," replied the leper, "I have already paid Isaka five cents, for he has been hiring the trap out every night at one cent a night!" I'm afraid I burst out laughing, because I thought it very enterprising on Isaka's part!⁹⁴

Some patients also managed to accumulate property while living in the settlements, taking advantage of the material support offered by the missionaries to improve their economic situation. For example, in her fourteen years at Kumi, one patient, Agnes, accumulated five cows, though without the knowledge of Miss Laing, who only found out when someone arrived at the settlement claiming that Agnes had bequeathed the cows to him. She wrote: 'I feel indignant to find that we were keeping this woman and all the time she was collecting wealth in this way and then these people just think they can walk in and take her possessions'.⁹⁵ Miss Laing also complained of patients who travelled in and out of the settlement during the year so that they would not be present during the cultivation season, which then necessitated that the settlement provide the patient with food during the remaining

⁹³ Birmingham, CMS/G3/AL Rosa Langley 1936.

⁹⁴ M. Laing, 'Children's Leper Home', *Mission Hospital*, 40.464 (September 1936), 248.

⁹⁵ SDA, X/NAF/9, Letter from M. Laing to DC Teso, 26 May 1947.

portions of the years.⁹⁶ If the patients in question were infectious, then the missionaries were far more likely to allow them to take advantage of the system, in the hopes that this would lessen the spread of leprosy.

Bad Behaviour

Uganda's leprosy missionaries wrote frequently of how happy their leprosy patients were, and how positive were their relationships. This may have been true for many leprosy patients, or at least for certain aspects of their lives, but it was certainly not true of all. This section will delve into the missionaries' infrequent reports of bad behaviour as a means of elucidating some of the more negative sentiments that patients may have harboured about life in a leprosy settlement. While the missionaries had to be flexible on some behavioural issues, there were others upon which they remained inflexible, particularly 'immorality', or sex outside of marriage, and alcohol. Although life in the settlements came with many material and economic advantages, there were also certain lifestyle changes that the missionaries demanded, with which not all patients were happy to comply.

Immorality was one of the problems mentioned most frequently by leprosy missionaries, and in all of Uganda's leprosy settlements it was grounds for a patient's expulsion. The lady missionaries at Lake Bunyonyi reported immorality as one of the greatest temptations that leprosy patients faced, even if they were devout Christians.⁹⁷ They accounted themselves lucky to have only one or two cases of immorality come before the Lukiko each year, and this was only after all the patients realised that being caught would result in expulsion. A policeman patrolled the settlement at night, with instructions to arrest anyone engaged in immoral activities. Reports of immoral behaviour, however, were far more likely to come from fellow patients, whether because they were Christian or because they had some personal reason to carry the tale. Miss Langley wrote of immorality:

⁹⁶ SDA, X/NAF/9, Letter from DC Teso, 16 June 1947.

⁹⁷ Birmingham, CMS/G3/AL Rosa Langley 1935.

You may say “How do you know this is not going on in secret”? I can assure you it is not so, for we have so worked the Christians up to the sin of it and how it spoils the work of God on the Island that they are the first to let us know if anything has been taking place of a suspicious nature’.⁹⁸

One former leprosy patient, who entered Buluba in the 1940s, reported that: ‘The Sisters would get to know wrong characters in our dormitories through getting them red handed by the guards or through the spies who wanted praises from the Sisters. One would even wonder how the Sister would fully know the details of any particular plan’.⁹⁹ Another reported that immorality was difficult ‘due to tight security by the Sisters who were not interested in grooming lovers but instead focusing on treating leprosy’.¹⁰⁰ As you would expect, however, the threat of expulsion, the policing of night time activities, and the propensity of some patients to report on others, did not render immorality within the settlement obsolete: ‘It is true there secretly existed love affairs amongst lepers but it was not allowed by the administration and the punishment would be expulsion without compromise. This however encouraged immorality like fornication and adultery since people would just sneak to meet their spouses’.¹⁰¹

While missionaries considered immorality to be the most severe form of ‘bad behaviour’ or ‘misconduct’ that a leprosy patient could engage in, another frequent problem was over-consumption of alcohol. This was not an issue that missionaries were inclined to report on frequently; mentions of drunkenness are extremely rare in the CMS and FMSA sources.¹⁰² According to former patients, however, the consumption of alcohol was a problem that could be dealt with very severely. At Lake Bunyonyi, the consumption of alcohol was absolutely forbidden, and those caught imbibing were punished with two days of

⁹⁸ Birmingham, CMS/G3/AL Rosa Langley 1936.

⁹⁹ Interview with Yoana, 28 April 2010 (Buluba, 1947, age 4).

¹⁰⁰ Interview with Vincent, 28 April 2010 (Buluba, 1944, age 18)

¹⁰¹ Interview with Yoana, 28 April 2010 (Buluba, 1947, age 4).

¹⁰² R. Langley, ‘Writes from the Leper Settlement’, *Ruanda Notes*, 57 (July 1936), 16; FMSA, e. Nyenga, Nyenga Annual Report 1945; FMSA, e. Nyenga, Early Days in the Leper Settlements, 1948.

solitary confinement on a small, nearby island: the same punishment given to petty thieves.¹⁰³ At Buluba, the consumption of alcohol, and specifically *mwenge*, was permitted, but only with specific authorisation from the missionaries.¹⁰⁴ However, the FMSA Sisters at Buluba had great difficulty controlling the behaviour of male patients, many of whom consistently slipped off ‘into the bushes’ to drink, their *mwenge* brewing hidden from detection by the tall elephant grass.¹⁰⁵ This was a particular problem in the case of certain individuals who had violent tendencies while drunk, and there are letters from the missionaries and Buluba’s headman to the DC, complaining of individuals who were ‘causing trouble’.¹⁰⁶ Several letters from 1940 refer to one man who, under the influence of alcohol, would sexually assault, beat, and foully curse women patients, in addition to less frequent physical altercations with male patients. On one occasion, his assault of a female patient led to her companions beating him severely, and he then threatened to assassinate one of these women. None of the punishments that the headman or missionaries felt empowered to mete out served as a deterrent, and until he was expelled, the limited repercussions for his actions encouraged several other men to follow suit.¹⁰⁷

In addition to drink and immorality, missionaries and former leprosy patients reported a wide variety of problems in the settlements, as you would expect to find in any community. These problems, such as theft, insubordination, marital strife, quarrelling, ethnic conflict, and witchcraft were usually dealt with internally, whether by the Lukiko, missionaries, or settlement chief. At Lake Bunyonyi, punishment usually consisted of two days solitary confinement on a small island, while at Kumi, punishment usually consisted of whipping or

¹⁰³ Interview with John, 11 August 2011 (Lake Bunyonyi, 1960s, age 15).

¹⁰⁴ FMSA, e. Nyenga, *Early Days in the Leper Settlements*.

¹⁰⁵ FMSA, e. Nyenga, Dr. Muir, Report on Uganda, 1938; JDA, Medical Leprosy, Letter from Settlement Headman to DC Busoga, 10 October 1940; Interview with Yoana and Vincent, 15 August 2011 (Buluba 1947/1944, age 4/18).

¹⁰⁶ JDA, Medical Leprosy, Letter from DC Busoga to Chief Secretary, 11 March 1946.

¹⁰⁷ JDA, Medical Leprosy, Letter from Settlement Headman to DC Busoga, 10 October 1940; JDA, Medical Leprosy, Letter from County Chief Bugembe to DC Busoga, 22 October 1940.

being locked up for a short time.¹⁰⁸ At Nyenga, the punishments were caning or public shaming, and at Buluba, caning, short imprisonment, or acts of penance, such as community labour.¹⁰⁹ Repeated ‘bad behaviour’ or ‘non-compliance with regulations’ usually led to expulsion.¹¹⁰ While the missionaries liked to write about the settlements as ‘beautifully pure’ and idyllic, in reality leprosy patients were involved in the same quarrels, dissatisfaction, and ‘misconduct’ that you would expect to find in any community, especially ones so heterogeneous in population.¹¹¹

Leaving the Leprosy Settlements

Most of the patients who entered Uganda’s leprosy settlements left again, whether a month later or decades later. A small number of leprosy patients died in the settlement each year, usually from an intercurrent illness. Taking 1946 as an example, 1.6 percent of the leprosy patients at Kumi died, 2.2 percent at Lake Bunyonyi, 2.4 percent at Nyenga, and 3.7 percent at Buluba. A slightly larger proportion of patients were discharged as arrested cases: 5.6 percent at Kumi, 4.2 percent at Lake Bunyonyi, 20 percent at Nyenga, and 32 percent at Buluba.¹¹²

The length of time that each individual patient stayed in the settlement before they were considered fit for discharge varied. At the CMS leprosy settlements, the missionaries liked to keep patients under observation for a year or two after the disease had apparently halted. A Kumi missionary once estimated that each patient stayed at the settlement for about four or five years before discharge, and a Lake Bunyonyi missionary wrote that she hoped leprosy patients would be able to return to their normal lives after 10 to 15 years of

¹⁰⁸ Interview with Sicola, 7 July 2010 (Kumi, 1931, age 9); Interview with Michael, 6 July 2010 (Kumi, 1952, age 10); Interview with Joy Gowers, 12 February 2010.

¹⁰⁹ Interview with John, 11 August 2011 (Lake Bunyonyi, 1960s, age 15); Interview with Margaret, 26 July 2010 (Nyenga, 1949, age 10); Interview with Francis, 27 July 2010 (Nyenga, 1953, age 18).

¹¹⁰ JDA, Medical Leprosy, Letter from DC Busoga to County Chief Butembe Bunya, 22 October 1940; FMSA, e. Nyenga, Nyenga Annual Report 1945; Interview with Yoana, 28 April 2010 (Buluba 1947, age 4).

¹¹¹ Birmingham, CMS/G3/AL Rosa Langley 1936.

¹¹² RCA, Kumi, Bunyonyi, Nyenga, and Buluba Annual Reports, 1946.

treatment.¹¹³ In 1946, 13 percent of Kumi's leprosy patients were arrested but under observation, as were 3.2 percent at Lake Bunyonyi. Nyenga and Buluba, however, were smaller leprosy settlements that constantly had to turn away patients who were seeking treatment, and therefore arrested cases were discharged much more rapidly. This most likely explains the difference in the proportion of patients discharged at the CMS versus FMSA leprosy settlements, particularly because discharged cases at Buluba frequently had to re-enrol, usually after about a year.

A small number of leprosy patients were expelled each year for bad behaviour, but the greatest proportion of patients left without official discharge, or as the missionaries said, 'absconding'. According to patient records at Buluba, wherein the arrival and means of departure of each leprosy patient is noted, most patients who were inclined to 'abscond' did so within a year of arriving. If a patient chose to stay beyond this first year, then it was much less likely that they would later leave without permission. Unfortunately, the missionaries rarely admitted to how many patients 'absconded', but a listing of statistics for those few time periods available indicates great variance by settlement and by year. At Lake Bunyonyi, in the first eighteenth months, from February 1931 to July 1932, six patients absconded, two were discharged, and several died, leaving 205 patients remaining.¹¹⁴ In 1936, out of 52 new patients admitted, 20 then left before the end of the year.¹¹⁵ At Kumi, in the beginning of 1950, 821 leprosy patients were present. During the course of the year, 591 new patients were admitted, 114 were discharged, 29 died, 25 were transferred to out-patient treatment, and 159 absconded. Overall, 15 percent of the Iteso patients 'absconded', 29 percent of the Bagishu, 14 percent of the Bakedi, 9 percent of the Lango, 3 percent of the Acholi, and 33

¹¹³ C.A. Wiggins, 'Retrenchment', *Mission Hospital*, 39.445 (February 1935), 34; Birmingham, CMS/G3/A11/2, Rev. B.R. Isaac, 'A Report on Tour of Ruanda-Urundi', 22 June 1948.

¹¹⁴ Birmingham, CMS/G3/AL Rosa Langley 1932.

¹¹⁵ KDA, Medical 1930-39, Lake Bunyonyi Annual Report, 1936.

percent of the Karamojong.¹¹⁶ At Nyenga, in 1939, of the 173 resident leprosy patients, 26 ‘absconded’, three of whom were close to being discharged symptom-free, and 23 of whom had asked permission to visit their families but never returned. An additional six patients were not counted because they arrived, spent a few days, and then left.¹¹⁷ Although these statistics are not complete enough to be representative of all four leprosy settlements between 1930 and 1951, they do at least indicate the possibility that about 15 to 20 percent of each settlement’s leprosy patients would ‘abscond’ each year, most within a year of arrival.

At Lake Bunyonyi, the decision over whether a leprosy patient was ready to be discharged was made during an annual survey, which took place in the winter over the course of a week or two, when the mission doctor examined each of the island’s residents in turn. Initially, arrested or symptom-free patients were asked to return to the settlement within a year, so that they could be re-examined for signs of leprosy’s recurrence: a frequent happenstance, given that the biomedical treatment for leprosy had a limited effect at this time.¹¹⁸ In the 1940s, Dr. Sharp increasingly took it upon himself to visit these discharged patients on his medical safaris, sending each chief a long list of former leprosy patients in the area and requesting that he gather them on the projected day of his visit. The CMS missionaries at Kumi followed a similar process, discharging patients in large batches once or twice a year, asking them to return for re-examination, and checking up on them through medical safaris. Nyenga and Buluba did not check up on patients through medical safaris, but Nyenga consistently recorded a very high rate of paroled patient attendance for check-up within six to twelve months.¹¹⁹

Not all leprosy patients who were considered fit for discharge wished to leave the leprosy settlements, which is perhaps unsurprising given that they could already have left if

¹¹⁶ RCA, Kumi Annual Report, 1950.

¹¹⁷ FMSA, e. Nyenga, Nyenga Annual Report, 1939.

¹¹⁸ Birmingham, CMS/G3/AL Beatrice Martin 1934.

¹¹⁹ FMSA, e. Nyenga, Nyenga Annual Report 1939; FMSA, e. Nyenga, Nyenga Annual Report 1944.

they were unhappy with the life there. In 1938, 37 leprosy patients at Lake Bunyonyi were pronounced symptom-free, but:

Practically all of them express a wish to remain on the island and to build up a new life there. One of last year's discharged lepers, a very interested "reader," returned to visit a friend on the island; when asked how he and his family fared he replied that they were quite well but they still wanted to come back because there was no church or teacher anywhere within reasonable distance of their home where they might continue to learn more about the Way of Life.¹²⁰

Of these 37, 10 were schoolchildren, and only one of those children actually wanted to return home, because his father was not a leprosy patient and wanted him home to look after the sheep. The others all had parents living on the island as well, and:

As I went round and told the children's parents that their boy or girl was cured they had numerous excuses that their children should stay on the island and not go and live with their relations. Some of the excuses were: "they will have no school to go to," "their relations are not Christians," "they have no money to support them," "they have been cured while living on the island and why should they go?"¹²¹

Many of the leprosy patients on the island were part of families, and this was always a problem when individual family members transitioned to a different health status, whether infectious, non-infectious, or symptom-free.¹²² Patients at Kumi and Ongino were also wont to receive their discharge with 'mixed feelings', asking if they could be re-admitted if they were not happy at home, and in the case of children, even crying profusely when a parent arrived to collect them.¹²³ At all of the settlements, there were several 'burnt-out' cases, men and women who were technically symptom-free, but could not return home because 'their relatives would not have them'.¹²⁴

At Nyenga, the day of discharge was presented as always a very happy one, when patients attained the 'freedom to return to their homes'.¹²⁵ Patient sentiments upon exit are

¹²⁰ 'The Healing Fellowship', *Mission Hospital*, 43.500 (September 1939), 239.

¹²¹ G. Mash, 'Tells of Joy on the Leper Island', *Ruanda Notes*, 68 (May 1939), 18.

¹²² Birmingham, CMS/G3/AL Grace Mash 1945.

¹²³ 'Leprosy', *Mission Hospital*, 42.488 (September 1938), 249; SDA, X/NAF/9, Letter from M. Laing to DC Teso, 15 September 1947.

¹²⁴ Leprosy Mission, 118/16, Letter from A. Downes-Shaw to Anderson, Secretary, Mission to Lepers, 12 June 1933.

¹²⁵ 'Our Least Brethren the Lepers', *Day Star in Africa*, 8 (January 1948), 19.

not mentioned in any records pertaining to Buluba, but it is easy to imagine that some who were still experiencing the symptoms of leprosy were not ready to leave, because in the 1940s large groups of patients who would have been considered worthy of treatment at the CMS settlements, were discharged from Buluba as ‘unsuitable’ because the government had pushed the missionaries to admit only infectious cases and children.¹²⁶

By the 1940s, leprosy patient discharge was not simply a matter of giving the former patient a certificate of discharge or a chit that proclaimed them free of leprosy, and then sending them on their way. A missionary or the DC would write to the patient’s local chief, asking if their relatives would be willing to help the discharged patient(s) by building a house and providing food while they started their own cultivation. If the relative replied in the affirmative, then they would send the patient onward, and sometimes even provide some assistance with the labour of building a home if their relatives could not initially manage on their own. The DC might send a letter like this:

These leprosy patients I write about here are old and their disease cannot infect other people. They can now be able to return to their places to stay there, however when they go there, they’ll need help in terms of food. I want you people to investigate and know whether the relatives to these leprosy patients can be able to help them and also if they would like to be looking after these old leprosy patients...

After you have assessed that their relatives can look after them but are lacking in housing and it’s difficult for these relatives to build for them houses, then I will personally help them on the arrangements of building small houses of mud and wood.¹²⁷

The Lake Bunyonyi missionaries and DC would sometimes arrange transport and porters for leprosy patients returning to their homes. At Kumi, the missionaries also helped arrange long-distance transport for discharged adult leprosy patients, which was then paid for by the patients’ respective local governments. The missionaries, DC, and Kyabazinga were

¹²⁶ JDA, Medical Leprosy, Letter from Sr. Felicity to DC Busoga, September 1944.

¹²⁷ Translation from Swahili, KDA, Leprosy, Letter from DC Kigezi to Chiefs Ndorwa, Rukiga, and Kinkizi, 9 August 1947.

similarly involved in arranging and paying for the transport of leprosy patients returning to their homes from Buluba.¹²⁸

Patient interviews and missionary records express a variety of reasons that patients chose to leave the settlements without being healed of leprosy, primarily centring on health, medicine, and lifestyle. Some left because they intensely disliked the painful injections that they were subject to weekly, or because they had endured the injections for some time without any visible signs of improvement. In the words of several former leprosy patients, some just ‘got tired of the hospital’, with its painful medicine, behavioural strictures, and separation from family. Or, ‘Maybe one would get tired of this place...want to be with his family’.¹²⁹ The behaviour and lifestyle expected of leprosy patients in a mission settlement was a cause of disgruntlement for some leprosy patients, and if the missionaries did not expel them for bad behaviour, they might leave of their own accord in frustration: ‘It is because some lepers were just hard to deal with and would often bring headache to the administrators. These were subjected to hard rules and so they opted to leave without permission’.¹³⁰ A sense of isolation or an infringement upon cultural taboos was also referenced as a reason for unhappiness or running away, for example in the case of leprosy patients who had travelled from a great distance to be admitted and could not speak the same language as other patients, or in the case of women who were told to eat eggs and chicken, though it was taboo.¹³¹ Fluctuations in settlement residents or management also caused some leprosy patients to leave the settlements, for example after Miss Laing retired as superintendent of Kumi, or perhaps if a close friend or family member was discharged.¹³² Some patients also left for economic reasons: ‘The loss of a productive member of the family was often a serious matter.

¹²⁸ JDA, Medical Leprosy, Letter from DC Busoga to Kyabazinga, 12 November 1945.

¹²⁹ Interview with Doreen, 30 April 2010 (Nyenga/Buluba, 1944, age 18); Interview with Jacqueline, 11 August 2011 (Kigezi/Kumi, 1970s).

¹³⁰ Interview with Yoana and Vincent, 15 August 2011 (Buluba, 1947/1944, age 4/18).

¹³¹ Interview with Jacqueline, 11 August 2011 (Kigezi/Kumi, 1970s).

¹³² Leprosy Mission, 119/5, Letter from A. Kent to Miller, Leprosy Mission, 29 September 1948.

On this account, patients at the colonies often decamped, because their children were left unattended at home'.¹³³ Younger patients might also leave the settlement in search of more lucrative employment; for example a group of three youths left the Bwama Island in 1937 to join a migrant labour party.¹³⁴

The missionaries reacted to the 'absconding' of leprosy patients depending upon their infectiousness and the example that they set to their fellow patients. In general, the missionaries at Lake Bunyonyi did not ask the local DC for much assistance in retrieving 'escaped lepers', except if they were infectious. On one occasion, however, the DC wrote to the chief of Maziba subcounty with the names of three leprosy patients:

If you will be able to see them, bring them before me at the headquarters. I want to convince them to return to the island for the lepers, well you know that we do not want to make them go there by force, but because these people are quite sick, and they can cause trouble to others, I want to convince them to go there on their own will.¹³⁵

When the three young boys ran away to join a labour party, Miss Langley wrote to the DC asking for help:

A week ago three of the children in the school, only mites of 10 yrs. of age ran away. They all leave crippled parents who are dependent upon them for help and they themselves are all infectious lepers...I am not troubling so much about the loss of the boys as the fact that if they are not brought back, other children realising they have gone and no steps have been taken and are earning good money, might do likewise.¹³⁶

Misses Laing and Kent at Kumi were far more aggressive in tracking down 'escaped' leprosy patients, especially children, and there are series of letters between the missionaries, DC, and chiefs wherein they try to find individual leprosy patients and persuade them to return to the settlement. The missionaries at Buluba followed a practice more similar to those at Lake Bunyonyi, writing occasionally to the DC with the names and addresses of people who had

¹³³ RCA, Minutes of the BELRA Uganda Branch Meeting, 19 April 1950.

¹³⁴ KDA, Medical 1930-39, Letter from R. Langley to DC Kigezi, 25 July 1937.

¹³⁵ Translation from Swahili, KDA, Leprosy, Letter from DC Kigezi to Chief Maziba Sub-County, 16 October 1941.

¹³⁶ KDA, Medical 1930-39, Letter from Langley to DC Kigezi, 25 July 1937.

left without completing their treatment, but making an extended effort only to track down infectious leprosy patients.¹³⁷

Conclusion

The men, women, and children who lived in Uganda's leprosy settlements had their own vision and priorities for their future, and they negotiated with the missionaries and settlement staff in order to pursue those goals. Some complied with and even took advantage of the medical, social, economic, and religious opportunities that the missionaries offered, while others conflicted with the missionaries, either negotiating a state of affairs that was more palatable to them, evading control within the settlement, or leaving the settlement altogether. Life in the leprosy settlement could be an opportunity, but it was not an opportunity that most leprosy patients adapted to in the way that the missionaries proscribed. Rather, leprosy patients shaped their own lives within the settlements, fashioning Christianity, biomedicine, and the trappings of 'civilisation' to suit their own needs and priorities, in concert with Ugandan staff, local and colonial governments, and European missionaries.

¹³⁷ JDA, Medical Leprosy, Letter from DC Busoga, 17 October 1944; JDA, Medical Leprosy, Letter from DC Busoga to Kyabazinga, 12 July 1946.

Conclusion

This thesis adds new perspectives to colonial medical, mission, and childhood history by covering three primary themes: the difference between Catholic and Protestant approaches to medical mission in colonial Africa; the interactions between and ideologies of colonial government officials and missionaries in the provision of healthcare; and the priorities and perspectives of missionaries and patients in colonial medical institutions.

Summary and Findings

Catholic and Protestant Medical Mission

In its analysis of Catholic and Anglican leprosy settlements in colonial Uganda, this thesis is the first to compare Catholic and Protestant medical mission in any depth. It shows that denominational differences in medical mission arose primarily because of the different resources available to each mission, and to a lesser extent because of the differential religious and social ideologies of Catholics and Anglicans. Whereas Catholic missions usually had more abundant financial resources than Protestant missions, it was Protestants who provided the earliest and most extensive biomedical care in Africa. Because canon law prevented Catholic religious from practicing medicine and surgery, Catholic missions faced great difficulties in supplying biomedically trained staff for their medical missions, which consequently limited the scope of their medical institutions and gave medicine, as opposed to education, a very limited role in the ideology of Catholic evangelisation in Africa. For many Protestant missions, on the other hand, the provision of biomedicine was a central tactic in their arsenal of evangelising techniques.

The Anglican CMS had minimal financial and staff resources for leprosy mission, and they could have chosen to create small leprosy settlements where their few missionaries would have had increased contact with individual leprosy patients. Instead, however, they chose to harness the potential of Ugandan staff and the cooperation of leprosy patients to

build large leprosy settlements, with up to 1100 in-patients, which were organised upon hierarchical lines that resembled the model of indirect rule used by the British colonial government. The CMS encouraged leprosy patients to live in family units that were largely self-supporting. These family units, often artificial amalgams of leprosy patients living without biological families nearby, then combined to create 'model villages' which were administered by leprosy patients whom missionaries had deemed responsible and Christian. Conversion to Christianity was a lengthy process, which could be achieved only after leprosy patients learned to read the Gospels, and accordingly the CMS missionaries placed great emphasis upon the educational and technical training of their patients. As a result of this training, the missions were able to supply most of the staff needed for their own settlements, and sent many other former patients to work for the colonial government.

The Franciscan Missionary Sisters for Africa, on the other hand, established smaller leprosy settlements with a higher ratio of missionaries and staff to leprosy patients. Given the Catholic Church's belief that salvation was based primarily on an individual's actions, the missionaries took advantage of greater staff numbers to monitor patients' behaviour, relying less on the authority of Ugandans to maintain order in the settlements. Even when granted large tracts of land for the growth of their leprosy settlements, the FMSA missionaries settled all of their leprosy patients within a small area, preferring the added expenditure of food provision to allowing patients to cultivate on the fringes of the settlement's land, away from supervision. Religious prohibitions on the practice of medicine meant that the development of Catholic medical mission was dependent on the service of a limited pool of lay doctors, which created enduring difficulties for the FMSA in Uganda and acted as a hindrance to the growth of large leprosy settlements. Within the settlements, conversion to Roman Catholicism required less time and education than conversion to Anglicanism, and

consequently Nyenga and Buluba always had higher proportions of converts than did the CMS settlements at Lake Bunyonyi and Kumi.

Leprosy held a special status for medical missions, and just as a study of leprosy work among two specific missions provides a narrow enough scope for the comparison of Catholic and Protestant medical mission, it also means that the characteristics of Franciscan and Anglican leprosy mission in Uganda cannot necessarily be extrapolated to represent all Catholic and Protestant medical mission ideologies in Africa. That being said, this thesis is the first attempt to set Catholic and Protestant medical institutions side by side for comparison, and the similarities as much as the differences that this juxtaposition highlights add depth to current historiographical understandings of the forces that shaped missions and responses to mission in African history. Medicine was an important component of mission, and the ideologies and resources of the missionaries who provided it influenced the lives of many Africans, sick and healthy.

Mission and Government Relations over Colonial Medicine

In its exploration of the shared ideologies and priorities of missionaries and colonial government officials in the provision of biomedicine, this thesis adds a new perspective on relations between secular and religious Europeans in colonial Africa. Contrary to the trend of divisiveness between mission and government medicine that has been reported in much of the literature on colonial medicine, in the case of leprosy treatment in Uganda, the distinction between religious and secular practice blurred. In cooperation with the missionaries, the Protectorate government shaped the medical and social response to leprosy in Uganda, and this partnership resulted in an approach to leprosy treatment that was atypical of medical missions or government medical centres standing alone. Until the transformation of leprosy control in 1951, religious and secular officials cooperated in prioritising the relief of suffering and the social, economic, and political aims of creating a 'civilised' Uganda through

engineering model communities. Despite their concerns for public health in Uganda, mission medical staff and colonial officials allowed concerns of benevolence, religion, resources, and staff to determine a policy towards leprosy control that colonial officials recognised not to be in the best interests of Uganda's public health.

While the particular circumstances and symbolism surrounding leprosy could be perceived as an exception to otherwise practical colonial public health policies, this thesis opens an avenue for further critical inquiry proving otherwise. It demonstrates the readiness with which government officials departed from the best practice of public health for social or ideological reasons, and points to the possibility that other diseases, as yet unexplored, received a similarly disproportionate amount of money and attention, perhaps also for the causes of benevolence, religion, and civilisation. Certainly leprosy was not the only disease on which Uganda's Medical Department spent far out of proportion to morbidity and mortality rates.

The Other Side of the Story: Uganda's Leprosy Patients

Uganda's leprosy patients were written about in more detail than any other set of individuals in Ugandan colonial history, and in discussing the perspectives and priorities of Ugandan men, women, and children who suffered or were saved from leprosy along with the perspective and priorities of the missionaries who wrote about them and managed the leprosy settlements, this thesis adds a unique perspective to Ugandan history and colonial medical history.

Life in the leprosy settlement was a negotiation between the vision of missionaries and colonial government officials; the realities of relationships between local authorities, 'untainted' families, and neighbouring communities; and the priorities of the patients who filled the settlements. Missionaries and government officials hoped to evangelise and 'civilise' leprosy patients so that they would be useful members of the British Empire, to earn

humanitarian credit for saving the outcast and vulnerable, and to decrease the incidence of leprosy in Uganda. Local communities and authorities wanted to curry positive relationships with the colonising British while maintaining their land, health, and political position.

Leprosy patients wanted to pursue their own happiness, health, and economic prosperity.

After all, entrance into a mission leprosy settlement was a choice, if not by the leprosy patient him or herself, then by their family or chief. This was not necessarily a choice made because Ugandans appreciated the value of biomedicine and Christianity, as the missionaries often liked to suppose, but rather a choice based on the economic, political, social, and medical priorities of the kin and community of a leprosy sufferer. Ostensibly, power lay in the hands of the missionaries who ran the settlements, but in reality the small numbers of missionaries and their inability to use compulsory measures meant that it was the patients who decided how and why they would stay in the settlements.

Integrating leprosy patient interviews with an abundance of documentary evidence about individual Ugandan leprosy patients, this thesis brings out their perspectives on entering, living in, and leaving the mission leprosy settlements. Such a wealth of documentation about any group of people in Africa is rare, especially considering that most leprosy patients were from the poorer echelons of society. The study of leprosy patients and settlements in Uganda thus furnishes an unusual opportunity to explore African perceptions of, experiences with, and agency within biomedicine and biomedical institutions in the colonial period, and to explore African interactions with colonial and mission institutions. In bringing out the perspectives of children and their families, this thesis also contributes to an under-researched area of African history: childhood.

Areas for Further Consideration

This study of leprosy settlements in Uganda, necessarily limited in its scope, also brings out questions for further reflection and research. Such topics include the imperial

character of leprosy work, which led to such detailed documentation about the settlements and their patients; the intermingling of British and Ugandan ideas about leprosy and the resulting shifts that took place in perceptions of the disease; and the changing nature of leprosy control in Uganda after 1951, when the government appointed a leprologist for Uganda.

The Imperial Character of Leprosy Work

The treatment of leprosy in the British Empire relied upon the mobilization of imperial networks of science and philanthropy.¹ From the late nineteenth century until the late twentieth century, leprosy enjoyed great popularity as a humanitarian cause, and in Africa it was arguably the most public philanthropic medical cause.

Leprosy was a thriving cause of Christian philanthropy in medieval England, and when, centuries after its decline in Europe, the British encountered leprosy sufferers in increasing numbers in the colonial world, leprosy again became a cause of philanthropic attention. Interest in leprosy was piqued most strongly by the death of Belgian missionary Father Damien from leprosy in Hawaii in 1889, after which the British popular and medical press abounded with discussions of leprosy, some of which were focused on Father Damien as a role model for the charity and compassion due to leprosy victims. In a speech at the launch of a new leprosy charity in 1890, the Prince of Wales explained that Britain had up until recently neglected the problem of leprosy because: ‘It was only last year that we had before us the case of one who lost his life through doing all he could to alleviate the sufferings of those who were afflicted by this fell disease’.² In keeping with the admiration of Father Damien’s humanitarianism and the concern over leprosy’s spread, over the course

¹ Research on leprosy and international scientific networks: M. Vollset, ‘Globalizing Leprosy: Production and Circulation of Medical Knowledge about Leprosy, 1873-1933’ (Ph.D., University of Bergen, forthcoming).

² ‘The National Leprosy Fund’, *The Times*, 14 January 1890.

of the 1890s, British men and women founded the largest concentration of leprosy charities in modern British history.

British leprosy charity experienced another spurt of growth after World War I, both because a trend towards the secularisation of philanthropy opened another avenue for leprosy humanitarianism, and because the supposed discovery of a cure for leprosy in 1921 meant that the widespread treatment of leprosy, and even its elimination, became feasible.³ Several scientists and philanthropists founded the British Empire Leprosy Relief Association (BELRA) in 1923, which with its explicitly secular and humanitarian agenda, quickly became the largest of Britain's leprosy charities, funding research and offering sizeable grants to leprosy settlements throughout the British Empire.⁴ Thereafter many medical missions began opening leprosy settlements throughout the British Empire, the largest number being founded in the 1920s and 1930s in Africa and India.

Leprosy was a cause of imperial philanthropic interest for a variety of reasons, encompassed by Christianity, humanitarianism, the 'civilising' mission, and patriotic duty. As discussed in the introduction and first chapter, leprosy had a special Christian significance, which meant that the healing of leprosy patients carried with it religious benefits and prestige, and that leprosy sufferers were more valuable converts to Christianity. As discussed in Chapters 2, 3, and 4, leprosy's in-patient treatment model created a perceived special opportunity for 'civilising' Africans that was attractive not only to missionaries, but also to government officials. Moreover, the visibly disfiguring and debilitating symptoms of leprosy, and the supposedly universal stigma attached to the disease, made it easy to portray leprosy victims as vulnerable sufferers, thereby turning leprosy into an attractive humanitarian cause. In one of their annual reports, BELRA went so far as to state that

³ F. Prochaska, *The Voluntary Impulse: Philanthropy in Modern Britain* (London, 1988), 81; 'The Treatment of Leprosy', *British Medical Journal*, 2 (19 November 1921), 851.

⁴ L. Rogers, *The Foundation of the British Empire Leprosy Relief Association* (Watford, 1945), 5; LEPRO, BELRA Annual Report, 1933, 5.

leprosy was ‘Worse than Slavery’, which had been the largest humanitarian cause of the previous two centuries.⁵

Finally, leprosy humanitarianism was cast as an imperial and patriotic duty of all Britons. From the nineteenth century, many Britons believed that philanthropy was a measure of the country’s international standing, and BELRA took advantage of this notion for fundraising, writing that: ‘It is a patriotic duty to try and make every part of the Empire as healthy as possible’.⁶ In their travelling exhibitions in Britain, BELRA displayed a film about leprosy entitled: ‘A Stain on Our Empire’s Flag’, and in several annual reports, BELRA tried to play on national pride by placing lacklustre British donations in comparison with leprosy fundraising in the United States, for ‘Let it never be said that Britain could not *control* this awful scourge because her people were not ready to supply the ammunition necessary to pursue a determined warfare’.⁷

The implications of Britain’s imperial philanthropic interest in leprosy were varied. As an imperial and a religious cause, leprosy drew enough resources from Britain to allow for the creation of in-patient settlements, which meant that colonial leprosy patients had a very different medical and social experience than most other colonial subjects who came into contact with biomedical institutions and missions. Because leprosy settlements in the Empire were tied to fundraising in Britain, through secular charities and missions, leprosy missionaries wrote frequently and extensively about the settlements and their inhabitants. Since leprosy patients were considered especially sincere and valuable Christians, those patients who converted were the subjects of even more detailed recording by the missionaries. Yet although this abundance of information is valuable to the historian, and

⁵ LEPRA, BELRA Annual Report, 1935, Cover; M. Barnett, *Empire of Humanity: A History of Humanitarianism* (Ithaca, 2011), 57.

⁶ Prochaska, ‘Victorian England’, 20; LEPRA, BELRA Annual Report, 1928, 13.

⁷ LEPRA, BELRA Annual Report, 1935, 8; LEPRA, BELRA Annual Report, 1929, 16-7.

brought in money with which to support the leprosy settlements, it is also an indication that in-patient leprosy sufferers were subject to far more surveillance than most imperial subjects.

One of the most enduring effects of the imperial character of leprosy control are the ways in which ideas of leprosy have shifted over the course of the twentieth century, often from acceptance or ignorance to stigma and neglect. The propaganda delivered by British leprosy humanitarians has contributed many misconceptions about leprosy which still linger today. Fundraising literature on leprosy consistently emphasised the disease's disfiguring symptoms, its contagion, and the stigma that supposedly attended all of its sufferers, whereas in reality only a minority of leprosy patients are disfigured, leprosy is only mildly contagious and leprosy morbidity rates are usually low, and its victims are not and never have been universally stigmatised.

Shifts in Ideas about Leprosy

More negative is the effect that British ideas about leprosy had upon the lives of those leprosy patients that they treated. In Uganda, most of the ethnic groups to which the settlements' leprosy patients belonged did not stigmatise leprosy, especially not within family units. Yet after the leprosy settlements were open for several decades, each of the ethnic groups whose regions hosted a leprosy settlement feared and stigmatized the disease and its sufferers.

Shifts in perceptions among the Bakiga over the duration of the Lake Bunyonyi leprosy settlement's years, from 1930 to 1967, demonstrate the adverse effect that leprosy mission could have. As discussed in the introduction, the Bakiga had a precise knowledge of leprosy, or *ebibembe*, and its symptoms, but did not stigmatise or neglect most of its sufferers.⁸ But by the time the settlement closed in 1967, leprosy was so feared in Kigezi that Ugandan medical staff would not touch patient records that had been in the pocket of a

⁸ A.C.S. Smith, 'Leprosy in Kigezi, Uganda Protectorate', *Mission Hospital*, 35.407 (1931), 312.

leprosy patient, workers refused to build a road near a leprosy hospital, and a wandering old woman with leprosy was incarcerated in a cattle shed at a prison until a hospital worker came to collect her.⁹

The shift from tolerance to fear of leprosy was most likely an unintended consequence of missionaries' leprosy control efforts: taking leprosy patients aside or away; having community and government authorities exert pressure on leprosy patients to leave home; and settling them on an island in a large lake. Missionaries saw education as vital to the elimination of the unhygienic habits and lack of dread that they perceived as responsible for the spread of leprosy among the Bakiga, and their 'medical safaris' and pamphlets were evidently successful in teaching fear.¹⁰ Dr. Sharp, for example, wrote that 'the little book that has been written for the natives to read for themselves explaining the dangers of untreated leprosy is beginning to influence the people and make them anxious for their afflicted friends to be treated'.¹¹ By singling leprosy out and encouraging government officials to remove leprosy patients from communities, missionaries also created an environment that made discrimination towards leprosy patients potentially beneficial, not necessarily for reasons of public health, as they intended, but for political, economic or social gain of relatives and local authorities. The segregation of leprosy sufferers on an island, though theoretically voluntary and not total in nature, further contributed to the growing fear of leprosy. One interview suggested that regardless of the degree of visible symptoms or disability caused by leprosy, only the patients who had lived in the leprosy settlement were subject to stigma.¹²

While the creation of stigma was surely not the intention of the missionaries, their assumptions about leprosy, medicine, Christianity, and Africa influenced the policies of singling out and segregating patients, thus gradually increasing the stigma towards leprosy.

⁹ Interview with Pat Gilmer, 4 November 2009.

¹⁰ L.E.S. Sharp, 'Kigezi', *Mission Hospital*, 32.364 (May 1928), 103.

¹¹ L.E.S. Sharp, 'Letter from Dr. Sharp', *Ruanda Notes*, 41 (July 1932), 11.

¹² Interview with Vicent, 5 August 2011.

CMS missionaries presumed the necessity for segregation, brought it into Kigezi and reinforced the myth of universal stigmatization. Their medical safaris emphasized the uniqueness of leprosy, and their education campaign exaggerated the prevalence of the disease and created an anxiety that was disproportionate to the morbidity threat that leprosy actually posed.

This brief overview of changing ideas of leprosy in Kigezi has wider implications for the study of shifting disease perceptions and the management of stigma. This takes on particular significance given the many resonances between leprosy and HIV/AIDS, as for example both diseases appear mysterious in causation, are potentially disfiguring and disabling in their symptoms, and involve extended medical patronage in treatment. Further research into attitudes towards leprosy in Uganda could add historical context to the handling and perception of HIV and AIDS in Uganda today.

Leprosy Control in Uganda after 1951

Until 1951, large in-patient settlements formed the basis of mission and government leprosy control policy in Uganda. From 1951, however, the in-patient settlements were augmented by increasingly widespread out-patient treatment across the Protectorate, and by smaller 'leper camps' run by Ugandan local governments. This shift occurred for four reasons: (1) the discovery of the first truly effective biomedical treatment for leprosy in 1947, which meant that larger numbers of leprosy patients could be treated and rendered non-infectious more rapidly; (2) an increased emphasis on social welfare and medical provision as a justification for colonialism following World War II, which was tied to (3) the appointment of a Protectorate leprologist for Uganda, and (4) the criticism of the East African Interterritorial Leprologist, Dr. Innes, for Uganda's existing leprosy control scheme.

The increased involvement of the colonial and local governments in leprosy treatment changed the nature of leprosy control to a programme that was theoretically more interested

in the public health of Ugandans, and less interested in leprosy as a means of evangelising and ‘civilising’ Ugandans. In the 1950s and 1960s, the treatment of leprosy became increasingly professionalised, with Kumi and Buluba opening training programmes for leprosy assistants.¹³ These men and occasionally women were then posted at dispensaries and small leprosy villages opened up by local governments across Uganda, and their work was loosely supervised by leprosy settlement staff and later by district government medical officials.¹⁴ The dispersal of biomedical treatment sites for leprosy, the increased financial resources poured into leprosy, and the shorter duration of treatment necessary to halt leprosy’s progress meant that biomedicine was a more attractive and available medical option for Uganda’s leprosy sufferers. Leprosy settlements also became places of research, as well as of treatment and care. They were the earliest Ugandan centres for the development of physiotherapy and prosthetics, and even today the former leprosy hospitals fit many of the artificial limbs needed by landmine victims from northern Uganda.

Yet in spite of all the seemingly positive changes to leprosy control policies in Uganda in the late colonial and early postcolonial period, by the end of the 1960s there were still many leprosy patients who were not accessing biomedical treatment for leprosy.¹⁵ Even when patients did travel to dispensaries or leprosy villages for biomedicine, they could not always rely on leprosy assistants to give adequate treatment to all patients under their care.¹⁶ Moreover, although the leprosy villages were intended to be ‘temporary settlements where patients can reside and support themselves for perhaps a year or more’, the villages did not necessarily have the resources to aid short-term residents in become self-supporting, if they

¹³ FMSA, Ten Years of Leprosy Control, Busoga, Uganda, January 1960-December 1969, 7; Kumi Hospital, Policy, Letter from Kumi Leprosy Centre to Dr. Brown, 11 May 1955.

¹⁴ JDA, Infectious and Contagious Diseases, J.A. Kinneer Brown, ‘The Treatment and Control of Leprosy’, 1953.

¹⁵ Interview with Pat Gilmer, 4 November 2009.

¹⁶ District Office of Health, Jinja, Uganda (DOH), Letter from Leprosy Supervisor Busoga to DMO Jinja, 10 April 1964; DOH, Letter from Leprosy Supervisor Busoga to DMO, 28 December 1962.

were even physically capable of cultivation.¹⁷ The turmoil that faced Uganda in its first decades of independence also affected medical and welfare service delivery. Many leprosy villages thus quickly degenerated into terrible conditions, especially if they were not within easy travelling distance of one of the large leprosy settlements.¹⁸

The eradication of leprosy had become the primary stated goal of leprosy control in Uganda, and in order to achieve this goal another shift in leprosy control had to occur.¹⁹ In the 1970s and 1980s, most of the government leprosy villages were shut down in favour of mobile out-patient treatment. The efficacy of leprosy control in any given area then depended upon a proactive district government leprosy officer or leprosy missionary, whose responsibility it was to locate all the district's leprosy patients and to arrange for leprosy assistants to travel across the countryside to deliver regular medication to any leprosy sufferers.²⁰ This avoided the problem of leprosy patients making their condition conspicuous by regular long journeys to the nearest leprosy village at a time when the stigma against leprosy was high, and the problem of supporting patients who needed prolonged treatment. Leprosy control thus became integrated into district medical departments, to be undertaken by Ugandan staff with funding from European and American missions and charities. The leprosy settlements, meanwhile, were either closed or recast as leprosy hospitals, with European missionaries handing authority over to biomedically trained Ugandans who acted under the auspices of Uganda's Catholic and Anglican churches.

The 1970s and 1980s saw great progress in eradicating leprosy from Uganda, and as the incidence of leprosy decreased and the incidence of HIV/AIDS increased, Uganda's Ministry of Health re-tasked the leprosy control system to treat patients of tuberculosis,

¹⁷ UKNA, CO 685/30, Uganda Medical Department Annual Report, 1951, 5; JDA, Leprosy 1960-69, Letter from DMO Busoga to Secretary General, African Local Government, Bugembe, and DC Busoga, 1 Feb 1960.

¹⁸ Interview with Pat Gilmer, 4 November 2009.

¹⁹ JDA, Infectious and Contagious Diseases, J.A. Kinnear Brown, 'The Treatment and Control of Leprosy in Uganda', 20 Feb 1954.

²⁰ Interview with Pat Gilmer, 4 November 2009; Interview with Gabuyeri and Ben Mayanja, 11 August 2011.

which has very similar bacteria to leprosy. Today, many of Uganda's districts have a joint Leprosy and TB officer, now primarily responsible for the management of tuberculosis, and there are no more than several hundred new cases of leprosy diagnosed annually in Uganda. Leprosy drugs are available at several former leprosy hospitals, provided free of charge by foreign humanitarian organisations. As the incidence of leprosy decreases globally, so too does humanitarian funding for the disease, and although several of the charities that supported leprosy work in Uganda from the 1930s retain a presence today, with their limited resources they are increasingly turning away from the support of debilitated former leprosy patients to the biomedical treatment of any new leprosy patients.

Further research into the history of leprosy control from 1951 to the present would tell an illuminating story about the decolonisation of medicine, the continuities of humanitarian medical interventions in Uganda, and the ability of certain medical causes to transcend times of political turmoil. The links between contemporary and historical medical humanitarianism in Africa have received very little scholarly attention, and given the extent of humanitarian involvement and interest in leprosy, a longer study of leprosy policy in Uganda could provide insight into the political, social, and medical roles that humanitarians play in Africa.

In focusing on the first stage of leprosy control in Uganda, between 1927 and 1951, this thesis highlights instead the interlocking ideologies, priorities, and actions of missionaries, the colonial government, Ugandan auxiliaries, and Ugandan patients in the context of leprosy settlements in colonial Uganda. It covers new territory by comparing the resources and beliefs that Protestant and Catholic missionaries brought to medicine in Africa; by demonstrating how interlinked the supposedly religious goals of the missionaries and secular goals of the government actually were; and by bringing out the voices and perspectives of Ugandan leprosy patients and their families, children and adult. Drawing on a wealth of new sources, this thesis adds to literature on the histories of mission, medicine, and

childhood in Africa, as well as to Ugandan history and leprosy history, by focusing on the religious and social experiences of Ugandan leprosy patients, and the ways that the involvement of Catholic and Protestant missionaries and government officials affected these experiences.

Appendix A

Leprosy Patients Interviewed

First Name of Interviewee	Date(s) of Interview	Settlement of Entry	Date of Entry	Age at Entry	District of Origin	Ethnicity
Aloysia	26 July 2010	Nyenga	1951	12	Kaberaimaido	Kumamu
David	28 April 2010	Buluba	1962	24	Mbale	Mugisu
Demetria	28 April 2010	Buluba	1961	30	Budaka	
Deo	26 July 2010	Nyenga	1951	21	Luwero	Mukiga
Dominic	26 April 2010	Buluba	-----	-----	Kamuli	Mulamogi
Donozio	21 April 2010	Buluba	1977	39	Jinja	Rwandan
Doreen	26 April 2010	Nyenga	1944	18	Mukono	Muganda
	30 April 2010 15 August 2011	After two years, Doreen was transferred from Nyenga to Buluba where she has lived ever since.				
Ezekiel	27 July 2010	Nyenga	1961	23	Luwero	Rwandan
Francis	27 July 2010	Nyenga	1953	18	Mayuge	Musoga
Jacqueline	11 August 2011	Kumi	1970s	18	Kigezi	
		Jacqueline was originally treated as an out-patient in Kigezi, but was transferred to Kumi for medical care for several years as a young woman in the 1970s.				
John	11 August 2011	Lake Bunyonyi	1960s	15	Kigezi	Mukiga
John	7 July 2010	Kumi	1960s	15 or 16	-----	Eteso
		After being treated for leprosy, John stayed on at the settlement as staff.				
Joseph	27 July 2010	Nyenga	1965	39	Bugerere	Mudama
Lawrence	6 July 2010	Kumi	1959	19	Kumi	Eteso
Leticia	26 April 2010	Nyenga	1952	6	Arua	Madi
Magadeline	26 July 2010	Nyenga	1958		Mbale	Mugisu
Margaret	26 July 2010	Nyenga	1949	10	Jinja	Musomyia
Margaret	6 July 2010	Kumi	1970	27	Manafa	Mugisu
Maria Goreti	28 April 2010	Buluba	1960s	Adult	Bugiri	Munyore
Michael	6 July 2010	Kumi	1952	10	Amuria	Eteso
Moses	21 April 2010	Buluba	1980	47	Kayunga	Muganda
Oluka	6 July 2010	Kumi	1949	19	Ngora	Eteso
Paulo	7 July 2010	Kumi	1950s	Young boy	Moroto	Karamojong
Paulo	7 July 2010	Kumi	1952	20	Budada	Mugisu
Proscovia	22 April 2010	Buluba	-----	-----	Kaliro	Mulamogi
Pulekeria	26 July 2010	Nyenga	1949	9	Mukono	Mudama
Samson	7 July 2010	Kumi	1951	21	Katakwi	Eteso
Scolostica	21 April 2010	Buluba	-----	Child	Kamuli	Musoga
Scovia	21 April 2010	Buluba	1980		Budaka	Mugwere
Sicola	7 July 2010	Kumi	1931	9	Kumi	Ateso
Silve	22 April 2010	Buluba	1955	Child	Iganga	Musoga
Sulemain	27 July 2010	Nyenga	1997	57	Mayuge	Musoga
Teopista	22 April 2010	Buluba	Obote	-----	Iganga	Musoga

			regime			
Tereza	26 July 2010	Nyenga	1952	4	Kayunga	Muganda
Tom	22 April 2010	Buluba	1954	6	Iganga	Musoga
Valetino	27 July 2010	Nyenga	1953	26	Kaberaimaido	Kumamu
Veronica	21 April 2010	Buluba	-----	-----	Tororo	Japadhola
Vincent	11 August 2011	-----	1970s	25	Kigezi	Mugwere
		Vincent lived in Kigezi and was treated as an out-patient for leprosy at the age of 25 in the 1970s.				
Vincent	28 April 2010 15 August 2011	Buluba	1944	18	Iganga	Musoga
Yoana	26 April 2010 28 April 2010 15 August 2011	Buluba	1947	4	Iganga	Musoga

Other Interviews

7 July 2010	Ademeus is the wife of David Livingstone Oitamong, and has lived in proximity to the Ongino leprosy settlement for most of her life.
7 July 2010	David Livingstone Oitamong is an elderly man who has lived near to the Ongino leprosy settlement since its opening.
7 July 2011	Francis Okwi is a Kumi local, and acted as my translator and research assistant in Kumi interviews.
12 February 2010	Joy Gowers is the daughter of Dr. Leonard Sharp, and spent much of her childhood living in proximity to the Lake Bunyonyi leprosy settlement.
3 November 2009 4 November 2009	Mary Sharp is the oldest daughter of Dr. Leonard Sharp, and spent much of her childhood living in proximity to the Lake Bunyonyi leprosy settlement.
4 November 2009	Pat Gilmer is a CMS nurse who travelled to Uganda in the 1965 to work at the Lake Bunyonyi leprosy settlement, and who managed out-patient leprosy treatment in Western Uganda until the 1980s.
August 2009	Reverend John Kimote's father was a leprosy patient at the Lake Bunyonyi leprosy settlement. He began working there as a teacher in the late 1940s, and later on in his life he was trained and ordained as a minister, appointed to Bwama Island sometime after the settlement closed in 1967.
23 August 2011	Sister Catherine, FMSA, travelled to Uganda as a medical missionary in the late 1950s, and over the course of her career spent some years working at Buluba.
23 August 2011	Sister Grace, FMSA, began agricultural work at the Buluba leprosy settlement in the late 1940s.

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