



**Global and local
contexts: the
Northern Ogoja
Leprosy Scheme,
Nigeria, 1945-1960**

*Contextos locais e
globais: o Programa
de Combate à Lepra
em Ogoja do Norte,
Nigéria, 1945-1960*

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Deriving funding from missionary sources in Ireland, Britain and the USA, and from international leprosy relief organizations such as the British Empire Leprosy Relief Association (BELRA) and drawing on developing capacities in international public health under the auspices of WHO and UNICEF through the 1950s, the Roman Catholic Mission Ogoja Leprosy Scheme applied international expertise at a local level with ever-increasing success and coverage. This paper supplements the presentation of a successful leprosy control programme in missionary narratives with an appreciation of how international medical politics shaped the parameters of success and the development of therapeutic understanding in the late colonial period in Nigeria.

KEYWORDS: Catholic missionaries, leprosy, Nigeria, international organizations.

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A missão católica Ogoja Leprosy Scheme aplicou, em nível local, os conhecimentos internacionais de ponta em lepra, com sucesso e resultados abrangentes, graças ao apoio financeiro de instituições missionárias da Irlanda, da Grã-Bretanha e dos Estados Unidos, assim como de organizações internacionais como o British Empire Leprosy Relief Association (BELRA). Tirou proveito também de avanços ocorridos no domínio da saúde pública internacional sob os auspícios da OMS e Unicef, na década 1950. O presente artigo combina a apresentação de um bem-sucedido programa de controle da lepra, por obra de missionários, com a análise sobre como as políticas médicas internacionais modelaram os parâmetros de sucesso e o desenvolvimento de conhecimentos terapêuticos na Nigéria, no final do período colonial.

PALAVRAS-CHAVE: missões católicas, lepra, Nigéria, organizações internacionais.

Introduction

In 1957 Thomas McGettrick, Catholic Bishop of Ogoja in Eastern Nigeria¹ penned a chastening meditation on the progress achieved in twelve years of Catholic missionary leprosy control in the north of Ogoja Province. Quoted in a medical missionary magazine published in Ireland, he wrote:

There are three stages in the elimination of leprosy: the first when every patient has a treatment centre near him; the second when all are receiving treatment and all the infectious cases are segregated; and the final stage when it is completely wiped out except for the few burnt-out cases in the segregation villages. It takes at least twenty years to reach the second or control stage when there will be no new cases — we have not yet completed the first step. It takes at least a century to arrive at the complete elimination stage. New cases are coming in every day in Ogoja (Chambers, 1957, p. 11).

Concurring with the growing recognition that, by the mid-1950s, Ogoja Province represented Eastern Nigeria's most persistent reservoir of new leprosy cases, McGettrick's assessment was targeted at a Catholic readership proud of "the heroism of her missionaries" (McGlade, 1967, p. 17) and willing to fund the works of these missionaries. His brief and strategically pessimistic overview of the process of leprosy control introduced an article by Sr. Visitation Chambers, the Irish doctor in charge of the Roman Catholic Mission (RCM) leprosy control programme in Ogoja, where the day-to-day running of the programme was described in some detail.

Chambers' presentation focused on the work of the religious sisters of the Medical Missionaries of Mary (MMM) in the leprosy hospitals and settlements of the region. This congregation of Catholic women religious² was founded in Nigeria in 1937 by an Irish woman, Mother Mary Martin, and was subsequently based in Drogheda, Ireland. Drawing most of its early vocations from Ireland, the congregation co-operated with another new Irish missionary order of priests, Saint Patrick's Missionary Society, Kiltegan,³ in many of their earlier ventures. This co-operation saw both organizations found their first schools, parishes and medical establishments in the two Eastern Nigerian Provinces of Calabar (contiguous with present-day southern Cross River State and neighbouring Akwa Ibom State) and Ogoja (contiguous with present-day Ebonyi and northern Cross River States).

The tone of Chambers' article is testament both to the relative isolation of Ogoja in the colonial scheme and the manner in which the Catholic Church interpreted its own provision of welfare services. Little mention is made of the role of any external organization, while the RCM Ogoja leprosy control scheme, which had primary responsibility for leprosy control in the north of Ogoja Province, resulted from a process of

negotiation with the British colonial administration in Nigeria and operated along lines agreed with the Nigerian Leprosy Service, using funding and medical capacities provided by a variety of organizations. There is mention of “quite a volume of official correspondence to cope with” (Chambers, 1957, p. 19), while the beneficent effect of a British Empire Leprosy Relief Association (BELRA)⁴ child adoption scheme is briefly mentioned as a consolation and a boon in providing extra food to school-children cared for and educated in the leprosy settlements. The work that forms the focus of the article, comprising supervision, education, management, and training for auxiliary African staff mostly drawn from among the patients, is represented as an outgrowth of a successful and well-organized religious mission.

Concluding her report on the development of leprosy control in Ogoja, Chambers remarks on the need for more specialized workers to administer ancillary diagnostic and therapeutic services. Commenting that “[as] ever in the Lord’s vineyard, the harvest is great — the labourers all too few” (Chambers, 1957, p. 22), she effectively recapitulates the longstanding bond between missionary Christianity and leprosy work noted in both contemporary reports and more recent scholarly accounts. Writing in 1951, Patrick Myers (p. 64) notes that religious organizations tend and maintain patients in most leprosy colonies worldwide, even in government-supported institutions, adding that “the Catholic Church alone has the credit of maintaining the largest number of such institutions — no fewer than 108 *throughout the Mission world*” (my italics).

More recently, Zachary Gussow (1989, p. 223) claims that, as a result of missionary involvement, “the care of lepers has evolved into a distinct and separate social and medical service, with its own outlook and tradition, its own staff structure and funds, and its own vested interest,” a point underlined in the case of the Cross River region of Nigeria by Irene Brightmer (1994, p. 65), who describes how leprosy “accidentally became a ‘different’ disease with a religious identity.” Unsurprisingly, Catholic missionary organizations such as Saint Patrick’s Missionary Society, Kiltegan, and the Medical Missionaries of Mary promoted their leprosy control work within the rhetorical tradition defined by their relations to European and North American patrons and donors, and their appointed missionary fields. As a result of this decontextualized tradition, it is difficult to discern from missionary narratives how decisive shifts in medical practices and resource allocation were affected in response to broader currents in international medical politics. Replacing the historical dynamic proposed in missionary narratives with one more sensitive to these shifts in medical politics and practice enables us to interrogate and understand a signally interesting case of the operation of global influences at a local level.

In this paper, then, I present an examination of the role of a variety of international organizations in the evolution of leprosy control in northern Ogoja Province in colonial southeastern Nigeria from 1945 to Nigerian independence in 1960. In this respect, it complements an analysis of the interaction between the colonial government in Nigeria and the missionary bodies which were given the responsibility for administering the day-to-day running of leprosy control programmes. From time to time in the course of this paper, I will sketch in the relevant aspects of the government-mission relationship, but the primary focus will remain on the international organizations identified as affecting the course of leprosy control in Nigeria. These international organizations varied in geographical scope, purpose and origin: while this list of variations is by no means exhaustive, it serves to distinguish the organizations whose work impinged on the development of leprosy control in Ogoja.

From the point of view of medicine and health, a series of rapid changes in public health policy and capacity in the 1940s and 1950s contributed greatly to developments in leprosy control. These changes, while implemented locally, were often coordinated at the level of national and colonial governments, and international organizations. The formation of the Nigeria Leprosy Service in 1945 enabled the coordination of clinical research in leprosy and the dissemination of medical knowledge throughout Nigeria's leprosy control schemes. Research at Uzuakoli, Eastern Nigeria, contributed to the standardization of diamino diphenyl sulphone (DDS) for the treatment of leprosy, adopted by the WHO Expert Committee on Leprosy meeting in Rio de Janeiro and São Paulo in 1952. It was felt that using new chemotherapeutic agents such as the sulphone drugs, sometimes alongside less radical 'cures' such as chaulmoogra oil, would make mass treatment of leprosy and interruption of transmission feasible in the 1950s (World Health Organization, 1958, pp. 250-3), and diminish the previous importance of segregation in the treatment of leprosy. At the same time, the post-1945 development and funding of epidemiological surveys and chemotherapeutic research was impacting on the treatment of a broad range of endemic illnesses worldwide. It is this context that the connections between the Medical Missionaries of Mary and international organizations concerned with leprosy, either specifically or as one among many public health issues, can best be assessed.

While the organizations emerging from the post-1945 United Nations (UN) structure, such as the World Health Organization (WHO), aspired to be truly global in scope, and other UN agencies such as the United Nations International Children's Emergency Fund (UNICEF) rapidly developed a global presence in the twenty years after the end of World War Two, organizations such as the British Empire Leprosy Relief Association (BELRA) in its various incarnations were largely confined

in geographic scope by the admittedly extensive boundaries of the British Empire. On the other hand, Catholic organizations such as the Kiltegas and the MMMs, though they administered their establishments on a local basis, largely independent one from the other, were answerable both to Church authority derived from the Vatican and to religious and financial patrons across a variety of locations.

In the interest of reflecting international pressures on policy formation and administrative direction, I shall focus my attention on the impact of BELRA, WHO and UNICEF on the work of the Kiltegas and MMMs in Ogoja Province. Through organizations such as Oxfam, the German Bishop's Fund (*Misereor*) and a variety of European and North American medical missionary training institutes contributed funds and expertise to leprosy work in Ogoja. These contributions were less decisive from a policy viewpoint and are not considered here. As a result of this discussion, I hope to develop a more nuanced sense of the nature of mid-twentieth century disease control policy, reflecting the commerce in ideas and solutions evolving over time in response to local instances and global understandings of a particularly complex medical crisis.

At the same time as we problematize the missionary accounts of leprosy work, we must be careful not to simply substitute the viewpoints of one set of interested and engaged specialists with those of another. While medical workers and historians share their sensitivity to the dynamics entwining the local and the global, this sensitivity may be attuned in different ways among each group. From the point of view of the historian, not normally a participant in events described, the meaning of concepts that are often taken for granted can be seen to have changed over time. In this way, the motives attributed to various actors through the history of leprosy control will be seen to have their own complex history and sources. In the Nigerian context, a variety of missionary, national, imperial and global bodies interacted in the field of medicine and of leprosy control, engendering a set of circumstances which, by introducing epidemiological survey techniques and capacities to new geographic areas, developing and standardizing chemotherapeutic advances, and developing the field techniques to deliver these advances to diverse and increasingly outpatient communities, are seen as pivotal in the development of our contemporary notions of disease control.

However, many of the beliefs and ideas informing these interactions often seem rather exotic when viewed from a contemporary perspective. For instance, a 1937 report of the British Empire Leprosy Relief Association (BELRA, p. 5), commenting on the significance of leprosy as a focus of particular government concern, stated that:

Leprosy may be compared to friction caused when fast-moving civilization comes in contact with the slow-moving life of backward races without the well-oiled gear of wisely planned advance. The impact

of western civilization on the primitive life of Southern Nigeria has been sudden. Governments and Missions are seeking to furnish the moral inspiration necessary to counteract the dangers of this impact.

By the same token, the language used by Catholic missionaries of the time yoked concepts of relief and social assistance together with an oft-repeated concern that the Catholic faith be imparted to the ill and suffering, as when Mother Mary Martin, foundress of the Medical Missionaries of Mary, writes that “several of our trained Sisters are leaving Ireland to bring relief and the consolations of our holy religion to the suffering lepers” (Martin, 1944, pp. 19-20). In terms of the original plans for the Ogoja Settlement Village, as an oratory stands at the heart of the clean quarters, so a Church is at the heart of the settlement complex.⁵ I give these examples at the outset to make the point that the concepts we understand rightly as compassion and concern, are bound up in an intellectual heritage, sometimes involving race, sometimes religion and spirituality, which both gives them their productive force and shapes the outcome of subsequent events.

BELRA and the RCM Leprosy Control Scheme, Ogoja

Deriving funding from missionary sources in Ireland, Britain and the USA, and from international leprosy relief organizations such as the British Empire Leprosy Relief Association (BELRA) and drawing on developing capacities in international public health under the auspices of WHO and UNICEF through the 1950s, the RCM Ogoja Leprosy Scheme applied international expertise at a local level with ever-increasing success and coverage. The development of mission medical capacity in Ogoja, alongside rapid innovation in leprosy therapy in the 1940s and 1950s, helped set the scene for the much vaunted focus on rural public health in post-independence Nigeria.

The backbone of the enterprise, and the source of much of the continuity underpinning its rapid growth, was provided by an Irish-based congregation of women religious, the Medical Missionaries of Mary (MMM). A note from 1956 (p. 2) describes the expanding leprosy service as “the work of eighteen Sisters, four lay doctors, one lay teacher and one lay nurse, helped, of course, by 100 African nurses.”

The quoted passage forms part of a description of the growth in the number of leprosy and general consultations in the previous two years, when the number of resident leprosy patients at central settlements and segregation villages grew from 8,100 to nine million, and the number of leprosy consultations from 32 to 34 thousand, among a population for Ogoja Province estimated in 1953 at 1,078,000 (Government of Nigeria, 1953, p. 292). This sign of commitment is reflected by the long service of Sr. Dr. Chambers, who worked in

Ogoja as a leprosy doctor and medical superintendent from 1948 to 1974. The involvement of the Medical Missionaries of Mary, during a period which saw the congregation grow in numbers and in geographical spread, greatly aided the international profile of Catholic mission leprosy control. This profile bore fruit in the aftermath of the 1948 film *Visitation*, with its focus on Ogoja, and with links between the MMMs and the Archdiocese of Boston, and, from 1955, between the newly-created diocese of Ogoja and Catholic funds and charities worldwide.

The work of the RCM in Ogoja was contextualized by the formation of a Nigerian national Leprosy Service in 1945 as part of a post-war Development and Welfare agenda in Britain's colonies. At the same time as government focused financial resources on already-existing leprosy centres at Oji River, Uzuakoli in Eastern Nigeria and Osiomo in Western Nigeria, increasing attention was being paid to the widespread prevalence of leprosy in Ogoja, further to the east and hitherto largely overlooked from the point of view of infra-structural development. Collaborating with colonial government and local Native Administrations to formulate leprosy control strategies appropriate to local conditions, the RCM Ogoja Leprosy Scheme benefited from therapeutic innovations developed in Nigeria and worldwide.

In the British colonial context, BELRA was one of the most important organizations for the co-ordination and pursuit of effective leprosy control. In existence since 1924, it combined the research experience of notables such as Leonard Rogers, R. G. Cochrane and Ernest Muir and the propaganda appeal of a missionary organization, so that "the Empire was brought into the forefront in the battle for the control of leprosy" (Cochrane, 1949, pp. 7-8). Building on the belief that leprosy was curable, a belief predicated on the apparent success of treatment with Chaulmoogra Oil⁶ in the Philippines and Calcutta, BELRA's role as a spearhead of leprosy research was confirmed when the organization's medical secretary was chosen as the first Honorary Secretary of the International Leprosy Association in 1931. The refinement of leprosy survey techniques in India, and the collaboration with the volunteering group Toc H.⁷ from 1934 helped bring about a climate in which coordinated leprosy control came to be seen as a viable form of social assistance (Cochrane, 1949, p. 8), while BELRA had much success in canvassing colonial governments to adopt concerted leprosy control policies from the late 1930s onward.

For the purposes of the RCM Ogoja Leprosy Scheme, the salient features of BELRA's engagement with leprosy control in Nigeria were its relationship to the formation of government policy in the post-war era and the expansion of its child adoption scheme, which attempted to address the needs of children within the specific context of the leprosy segregation settlement. The insights garnered from Roger's experience with the effective non-segregated treatment of early cases

of leprosy at dispensaries in India, South Africa and the South Pacific (Rogers, 1949, pp. 4-5), married to Muir's observation of the success of clan-based settlement schemes in Uburu and Oji River in Eastern Nigeria in the 1930s, were elaborated into a preferred programme for the extension of leprosy control amid the political and social circumstances of colonial Nigeria. This was in essence the scheme adopted by the nascent Nigerian Leprosy Service after 1945, and it proved an influential template in broader African and international contexts where local social, political and epidemiological contexts needed to be taken into account in developing disease control strategies. BELRA acted both as a *de facto* government advisory body and as a grant awarding body in the early years of the functioning of the Nigerian Leprosy Service, thus confirming through its quasi-formal role in Nigeria the imperial remit of its title. Negotiations between the colonial administration and the RCM led to the arrival in 1944 of an Irish leprosy doctor, Joseph Barnes, followed in April 1945 by three MMM Sisters to begin the hitherto largely neglected work of leprosy control in Ogoja.

While BELRA were originally loath to grant money to the planned RCM Ogoja Leprosy Scheme,⁸ the accounts of the Scheme for 1946-1947 show a grant of £1,020 from BELRA for equipment for a laboratory, a hospital and clinics, as well as for a kit-car for transport, in spite of Barnes' unwillingness to carry out the leprosy survey which had originally been a condition of assistance. The softening of BELRA's position on this matter is of a piece with its perceived position with regard to evolving British imperial policy on Colonial Development and Welfare. Following the recommendation of the International Leprosy Congress in 1938 that leprosia should pass from voluntary agencies into government hands, BELRA was concerned that its resources not be exploited as an excuse to limit government funding of leprosy control. As a result, BELRA indicated its intention to focus primarily on what it referred to as pioneer efforts, an aim attested to in a memorandum reproduced in its *Annual Report* of 1945. This complemented an accompanying assertion that: "the relief of leprosy is only partly a medical matter; the environmental influences, social, educational and spiritual, are no less important, and for these BELRA and the missions will still furnish staff and equipment" (British Empire Leprosy Relief Association, 1945a, pp. 4-6).

This would be coupled with the opening of a BELRA Nigeria Committee, mooted for 1947 (British Empire Leprosy Relief Association, 1946, p. 7), which together with its research capacity in Uzuakoli and its central position in the development of the national Leprosy Control Board placed BELRA very much at the heart of Nigerian leprosy policy in the crucial years between 1945 and 1950.

The scope of the BELRA Child Adoption Scheme, begun in a small way just prior to World War Two, became at once more ambitious

and more highly organized from 1947. It was noted that: “The claim of children to priority of consideration in treatment is unchallenged no less because they offer the best point from the medical angle of attacking the disease than because of the natural desire to give the rising generation a fairer chance in life” (British Empire Leprosy Relief Association, 1946, p. 8).

The centralisation of this programme after 1947 allowed the payment of block grants to Leprosy Settlements, placing less of an administrative onus on the settlements themselves, and was extended to Ogoja for the first time in 1949, in the wake of a successful campaign for more sponsors, which involved the British Royal Family. BELRA also provided sulphetrone to Ogoja in addition to the Nigerian Government supplies of dapsone.⁹ By 1955, 389 of BELRA’s 2,134 adoptees in Africa were in the RCM’s northern Ogoja settlements, a proportion that grew throughout the 1950s to reach 789 of 2,799 adoptees by 1961 (British Empire Leprosy Relief Association, 1956, p. 8; *idem*, 1961, pp. 10-1). This rapid expansion seems to corroborate the notion held in common between missionaries and international organizations that intervening in the transmission of leprosy to children, and catching the disease at an early stage, represented the best opportunities for controlling leprosy. It also acts as a reflection of the expanding numbers under treatment in Ogoja as the capacity of the RCM scheme expanded through the 1950s, underlining the cost to the scheme of housing, maintaining and educating a growing number of young patients whom as yet were unable to sustain themselves.

UNICEF, the WHO, and the RCM Leprosy Control Scheme, Ogoja

For both BELRA and the Medical Missionaries of Mary, much use was made of the fact that, as Maggie Black (1996, p. 6) writes: “The image of the suffering child is one of the most potent images of the 20th century. The child in distress is often used as a visual symbol for far larger issues: war, famine, pestilence, catastrophe, poverty, economic crisis.”

The explicit connection made between children in donor countries and children in Africa and in Ogoja served to highlight the recognition that “children are the key point in the attack on the disease” (British Empire Leprosy Relief Association, 1947, p. 7). A later edition of the BELRA Annual Report mentions the involvement of schools, Sunday schools and scout groups in fund-raising (British Empire Leprosy Relief Association, 1955, p. 4), while the MMM periodical, *The Medical Missionary of Mary* ran a regular children’s page with stories, competitions and messages of gratitude for funds raised from individual children and from groups. The connection made thus would continue to be at the

forefront of propaganda on leprosy throughout the period under consideration. As disease control policies changed, with the development of sulphone therapy and the subsequent possibilities of mass discharge from leprosy settlements and the shift away from segregation-based schemes, BELRA was in many ways a bridgehead between these old *cordon sanitaire* and segregationist policies and new policies aligned with WHO/UNICEF mandates.

The continued salience of child-centred initiatives adds to a sense of continuity across the diversity of programmes in place in the 1950s, a continuity underlined by the experience of leprosy control in specific locations. For the Medical Missionaries of Mary and the Roman Catholic Mission in Ogoja, the funding provided by BELRA and by UNICEF, as well as the advice and expertise made available by the Nigerian Government, assisted in the elaboration of a programme that married the specifically Catholic concerns of evangelism and of denominational health services with a response to the health care needs of local communities. The way in which this marriage was understood shifted in response to changes in the medical engagement with African communities, as global resources were focused in earnest on the areas and groups with whom the missionaries had long been in contact.

Though BELRA was essentially an agency of informal empire, its international scope put it in an interesting position with regard to UN-related agencies emerging from the post-war political world. In 1953, the Medical Secretary of BELRA undertook a leprosy survey for the WHO in Turkey, and became Technical Medical Adviser to the American Leprosy Missions, as well as co-operating with colonial governments in setting up leprosy research centres in Uzuakoli and in East Africa. In this regard, it had an important role to play in the development of the institutional capacity, which would be both harnessed and extended in the period of mass disease campaigns inaugurated by the WHO and other international UN-related bodies in the 1950s.

Maggie Black (1986, p. 90) refers to the disease control schemes of the 1950s as “this huge and theatrical health exercise” and mentions UNICEF’s role as “only one player... but an important one.” Leprosy control in the years after World War Two offered players a “theatre” in more than one sense, where intense dramas were played out both as on a stage and as in a war. The stage for this theatre was set by the developing capacities for intervention of powerful global health and welfare bodies funded by donor governments in the aftermath of World War Two.

The intervention of UNICEF and WHO in Africa in the 1950s was problematized by the political status of much of Africa, it being under ‘metropolitan’ colonial control. As Iskander (1987, p. 1) writes,

The Metropolitan powers at the time were reluctant to encourage “interventions” by the United Nations and its specialized agencies. They had their own plans for the development of their territories and since 1946, in the face of growing national agitation, had made funds available for ten-year programmes aimed at the development of economic resources and the raising of living standards in Africa.

It was also crucial that methods of cooperation, both between WHO and UNICEF (as technical and material aid bodies, respectively) and between these bodies and other groups engaged in disease control and preventive medicine, be elaborated through the process of engagement with bodies on the continent — colonial powers “wished [technical and humanitarian] agencies to integrate their own efforts in to the existing development programmes rather than initiate new efforts” (Iskander, 1987, p. 2).

The template for this engagement had already been set in other parts of the world. The cooperation between the WHO and UNICEF was initiated in 1948 at the request of the Yugoslav Health Administration in response to problems posed by endemic syphilis in post-war Bosnia (World Health Organization, 1958, pp. 202-3). It developed through the early 1950s as mass campaigns against the endemic treponematoses were undertaken in Haiti, and Indonesia, where an already existing rural health scheme had been successfully used. The impact of these campaigns had a number of implications for leprosy control in Eastern Nigeria, and impacted strongly on the pace of expansion of leprosy control in Ogoja. The most obvious impact is described in the following passage from a survey of the first decade of the WHO (World Health Organization, 1958, pp. 204-5):

The field work [in the Eastern Region of Nigeria] has been done by teams of from ten to fourteen trained auxiliaries... The co-operation of the people has made it possible to call together 1,000 to 1,500 persons at one time... A survey for leprosy and mass immunization against smallpox and yellow fever are carried out at the same time.

The referral of suspected leprosy cases in the Ogoja, Ikom and Abakaliki Divisions of Ogoja Province to local leprosy settlements helped increase the coverage of the Ogoja scheme, and prompted a rapid growth in the number of treatment centres and clinics attached to the scheme.

WHO-UNICEF co-operation also impacted directly on the treatment of leprosy. With the report of the WHO expert committee on leprosy presented in Rio de Janeiro in 1952, a strong boost was given to the emphasis on sulphone therapy and specifically on diamino diphenyl sulphone (DDS), already evident in the Nigerian leprosy control programmes. The subsequent material assistance programme whereby UNICEF provided sulphone tablets to the Nigerian leprosy control

programme from 1954 freed government resources and aided the development of capital programmes, both through the donation of transport and by providing the government with the opportunity to channel funds into building programmes for a growing rural health service. Also for the first time, with the epidemiological machinery of UNICEF, a detailed picture emerges of the rates of default, the age and sex profile of the patients, and the course of the infection in an individual under treatment.¹⁰

Conclusion: reframing religion and medicine

For the Medical Missionaries of Mary, the experience of the 1950s led to a new focus on the links between religion and medicine. While a strong sense of these links had always been at the heart of the congregation's self-conception, the era of African independence and of new understandings of international aid and development seemed to put new medical services and ideas at the vanguard of a politics of identity, which drew European missionaries and African families and communities together. Thus we read:

...modern methods of treatment of their everyday maladies... are slowly but surely drawing... our people away from their superstitious practices and erroneous conceptions and making them seek remedy for sickness and ill health in the hospitals and clinics.

In their enlightenment, they see beyond such renowned personages as Professor Rontgen, and Pierre and Marie Curie, the Omnipotent God who has fashioned and shaped such superior intellects, and whom they wish henceforth to serve (O'Mahony, 1958, pp. 4-6).

The increasing specialization of MMM medical workers as women of science, operating as educators and development professionals¹¹ evolved alongside changing patterns of international intervention in African health care issues. The growing co-articulation of science with religion visible in MMM publications from the late 1950s, while not explicitly acknowledging the contribution of international organizations to the medical work of Catholic missions, complicates the simplistic association of missionary rhetoric with ahistorical narratives of missionary enterprises. The purpose of this paper has been to supplement a reading of missionary sources, detailing in this instance the religious significance of leprosy work, with an appreciation of the historical dynamics that shaped the field of operation of these enterprises.

In short, then, the centrality of Ogoja, both in MMM perceptions of their work and from a point of view of propaganda, coupled with the increasing social and medical complexity of leprosy control schemes in an era which saw the shift from segregation to out-patient treatment and from imperial to global worldviews, makes the

Ogoja Leprosy Scheme a powerful index of trends in charity, aid, African politics, and the development and reception of medical technologies and strategies in the period between the end of World War Two and Nigerian independence in 1960.

NOTES

¹ In the colonial geography of Nigeria, the terms Eastern and Western Nigeria, refer to the eastern and western portions of the area comprising the southern third of the colony. The remainder of the territory, including the middle belt and the predominantly Muslim north, was administered as Northern Nigeria.

² The term 'women religious', denoting that the women in question are professed members of a religious order, is more accurate in this instance than the more commonly used term 'nun', which properly refers to members of cloistered orders. Medical Missionaries of Mary refer to themselves in writing as 'sisters'.

³ Saint Patrick's Missionary Society are commonly known as Kiltegan Fathers or Kiltigans, after the town in Ireland where they are based — Thomas McGettrick, Prefect Apostolic of Ogoja from 1940, and Ogoja Diocese's first bishop from 1955, was a Kiltegan missionary priest.

⁴ The British Empire Leprosy Relief Association was founded in 1924. Now known as LEPRA, the word 'Empire' was dropped from the name of the organization at an Extraordinary General Meeting in June 1957, though the short title BELRA continued to be used until the end of 1963. The new short title 'Lepra' was adopted on first January 1964. The meeting of Leonard Rogers and Frank Carter with Frank Oldrieve of the Mission to Lepers in Spring 1923, which led to the founding of BELRA, is described in Rogers (1949).

⁵ A map of the Ogoja Leprosy Settlement, with a key to buildings, is reproduced in *The Medical Missionary of Mary* (1948)

⁶ Specifically, the late 1940s and 1950s saw the gradual superseding of chaulmoogra oil in the treatment of leprosy. Chaulmoogra oil, a derivative of the *hydnocarpus* tree, has been described by John Iliffe (1987, p. 225) as "literally, a *confidence* trick" [italics in original] which provoked natural arrest in leprosy as a result of its implementation amid improving segregation strategies and allied nutritional and healthcare advances, rather than effecting a cure for leprosy. The replacement of chaulmoogra oil with sulphone therapy greatly abetted the control of endemic leprosy and brought about much of the impetus towards the internationalisation of leprosy control efforts.

⁷ Toc H was a volunteer organization founded under the direction of P. Clayton by workers at a rest home, during World War One. The unusual name derives from the telegraphic address of Talbot House, the original home of the foundation in Poperinge, Belgium.

⁸ Nigerian National Archives, Enugu (NAE), OGPROF 2/1/1788, p. 148. Memorandum from the Director of Medical Services, Lagos to the Senior Health Officer, Eastern Provinces, Enugu, dated 19th March 1940, endorsed to the Resident, Ogoja on the 25 March, 1940. The endorsement asked that McGettrick be informed of the decision of the Nigeria branch of BELRA, meeting on 9 Mar 1940, not to approve a grant to the Ogoja Provincial Leprosy Board. This decision was reached on the grounds that a detailed plan of work had not been submitted.

⁹ Joseph Barnes was unconvinced by the use of dapsone in treating leprosy, as he objected to what he saw as its excess toxicity in the doses administered in the late 1940s. Prior to its standardization, and its adoption as the chemotherapeutic agent of choice by the Nigerian Leprosy Service, Barnes obtained sanction to use sulphetrone, another sulphone derivative, in its place.

¹⁰ Copies of many of the returns compiled for UNICEF by the Ogoja Leprosy Scheme are still to be found at the MMM convent in Ogoja. The details of default rates, age profile and sex are provided, as are numbers referring to in- and out-patient status, all of which was crucial to the development of sensitive disease control policy instruments in the 1960s.

¹¹ Medical Missionaries of Mary (1962, p. 67) gives an indication of the strategic vision for health care that had emerged from 25 years of practice in Africa and Ireland.

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