NIU Journal of Humanities Copyright©2022
Nexus International University ISSN: *3007-1704*; 7(2): 71-78

A Historical Study of Leprosy Control Policies in Western Nigeria, 1896-1945

ALBERT O. ONOBHAYEDO
University of Benin, Benin City, Nigeria

Abstract. This study is within the domain of medical history, a neglected area of studies in Nigeria that is gradually gaining the attention of Nigerian historians**.** The study examines the institution of leprosy control policies in colonial Western Nigeria up to 1945, when the foundation of what became the basic control modalities was laid. The study analyses and provides insight into the early years of leprosy control in Western Nigeria, thereby filling the gap in a number studies. The study reveals that the colonial authorities disapproved of the indigenous method of leprosy control. They introduced new medicines such iodide of potassium, hydreg perchloride and chaulmoogra oil, but emphasised the seclusion of lepers in leprosaria. Leprosaria in the form of asylum, camps and settlements were created across Western Nigeria to facilitate the seclusion policy. The study also analyses the synergy between the government, Native Authorities, Christian missions, international agencies and families in the funding and management of the leprosy centres. To meet the objectives of the enquiry, the study relies substantially on primary sources especially the extraction of information from the national archives, Ibadan, while relying more on the Annual Reports of the Medical Department and related files.

Keywords: Leprosy, Western Nigeria, Leprosaria, Medicine, Ordinance

1. Introduction

This study in the social history of medicine focuses on the foundation of leprosy control policies in Western Nigeria. Only a few studies have interrogated leprosy control in Nigeria from a historical perspective because of the lean attention that Nigerian historians have paid to medical history, relative to political and economic themes. However, reference to developments in Western Nigeria has featured in some works written by some medical doctors and a few historians, although none has focused on leprosy control policies in the area and time under consideration. For instance, although Ralph Schram in his work, *a History of Nigerian Health Services*, paid attention to Western Nigeria, his account was of a composite nature, covering the whole of Nigeria and capturing both preventive and curative medicine, with emphasis on the latter (Schram, 1971). The work provides useful ideas, yet does not share the focus of this study. Tunde Oduwobi's study, *Tackling Leprosy in Nigeria, 1926 -1960,* also gives insight into the subject of leprosy control in Nigeria (Oduwobi, 2013). However, he left out the period before 1926, a period when some major developments took place in Western Nigeria. Unlike the focus of Oduwobi's work, John Manton's *Global and Local Contexts: The Northern Ogoja Leprosy Scheme, Nigeria, 1945-1960,* was centred on Ogoja in the middle belt of Nigeria, with only cursory reference to developments in Western Nigeria. He emphasised the influence of international agencies especially United Nations agencies like UNICEF, World Health Organization (WHO) and the British Empire Leprosy Relief Association (BELRA) which was later renamed British Leprosy Relief Association (LEPRA) in 1964. The span of the work excludes the period before 1945, which, indeed, was a significant part of the foundation years of the leprosy control policies in Western Nigeria. This gap is addressed in this study to reveal the synergy between the colonial authorities, the Christian missions, Native Authorities, local communities, families, international agencies and patients at various times up to 1945 in the control of leprosy in Western Nigeria.

Western Nigeria refers to the South-western end of Nigeria and is coterminous with the defunct Western Region of Nigeria as constituted by the Nigerian colonial state in 1951. It is occupied mostly by the Yoruba, the Edoid elements, the Anioma people and a sub-set of the Ijaw people, The common administrative umbrella foisted on them under the Western and Central Provinces in 1906, Western Group of Provinces in 1939 and as the Western Region in 1951 ensured several points of convergence in the development of leprosy control policies in the area.

2. Beginning of Leprosy Control in Western Nigeria

The adoption of preventive healthcare measures against leprosy was inspired by the need to check the spread of diseases, minimize recourse to hospital care and reduce death rate. Leprosy, the focus of this study, an infectious disease caused by *Mycobacterium leprae*, was present in virtually every community of Western Nigeria. Cases were reported across the region, including places like Abeokuta, Ijebu Ode, Ibadan, Lagos, Ogbomosho, Benin, Agbor and Asaba. The indigenous people had ways of dealing with it, which the British colonialists ruled out as ineffective and even hazardous to health. In the traditional setting, Lepers often roamed the streets, until their cases became conspicuous and complicated with chronic ulceration. Only those with chronic ulceration were sometimes ostracized from their homes. In some instances, as it was reported "among the Eguns, it [was] thought of as nothing; lepers intermingling with others in perfect ease and comfort". (National Archives Ibadan (NAI) Lagos Annual Report, 1906, p.220)

There was no known herbal decoction considered efficacious in preventing leprosy in any community in western Nigeria. But herbal mixtures were compounded for therapeutic uses. In Yorubaland, for instance, an indigenous plant called "*fu"* was used. It was selected from the bush and the bark split off ritualistically on four sides – north, south, east and west. The herbalist placed four cowries on those sides and repeated an incantation. The essence of the cowries was to pay the plant for its service in healing. Slag from the blacksmiths furnace was then placed in the bottom of a pot and mixed with the compound. The urine of a young to which the ordinary blue dye has been added was poured over this, along with small quantity of water. The mixture was covered and allowed to stand for seven days. The infested person then drank with his hand first and thereafter wash the leprous spot with the compound. (NAI, Lagos Annual Report, 1899). Apart from its contagious nature and its tendency to disfigure the patient, leprosy was looked upon as a curse from the gods or as a result of a dreadful offence that must have been committed. Many communities in Yorubaland and the Edo and Anioma axis of Western Nigeria also considered it hereditary. A case arising in a family tended to deter marriage to someone from that family. Being a stigmatised disease, families usually ostracised those with visible ulceration to save themselves from ridicule. A secondary reason was to prevent its possible spread to other members of the family. An ostracised leper usually set up a camp close to a farm land but was surreptitiously visited by family members, a habit that negated the desire to prevent the spread of the disease by seclusion. Another limitation of the indigenous effort at seclusion is that it was not rigidly enforced and there was no mechanism for detecting early stages of the disease, which were potentially as infectious as the large ulceration stage. British officials dreaded the possibility of being infected and had to include preventive measures against leprosy in their health calculations.

3. Colonial Rule and Prophylactic Isolation: Leprosaria

Upon the institution of colonial rule in Nigeria, the British were confronted by several tropical diseases one of which was leprosy. The virulent and incessant attack of the disease coupled with its contagious nature, correspondingly attracted the policy of prophylactic isolation. An institutional mechanism and policy in the form of isolation centres were contrived to foster environmental protection against the diseases. Leprosaria, inadvertently, emerged under this policy. The idea was to treat the diseases in isolated and specialized institutions. This was a containment policy because of the risk of causing nosocomial infection in General Hospitals if cases were referred there. Thus, preventive isolation was adopted and preferred to conventional hospital and therapeutic care. This required a clear-cut isolation policy, which demanded that lepers should be kept in leprosaria and it was first attempted in Western Nigeria at Kokomaiko in Lagos under Governor Molony. By 1896 a leprosarium had been opened at Yaba. The Yaba Leper Asylum commenced operation with two female patients. In 1897, one more female and two males were admitted. In 1898, three males and two females were also admitted. By 1889, the number rose to thirteen – eleven males and two females. Of the former, five were prisoners from Lagos prison and eight paupers. (NAI, Lagos Annual Report, 1899). Of the ten patients admitted between

1896 and 1898, two were indigenes of Lagos, while three were from the other parts of Western Nigeria simply referred to as the "hinterland" at that time. The asylum was expected to admit destitute patients, those from prisons, individuals who had lost faith in traditional medicine practitioners and those recommended by families, irrespective of the stage of the disease. Oguntola Sapara in 1901 classified the inmates into three: (1) those compelled to stay due to long sentence; (2) those finding that their ulceration had healed. (3) Those that were too mutilated to be useful to themselves and compelled, thereby, to remain (Sapara, 1899). By 1900, fifteen cases were admitted from western Districts and Lagos area. Of these, five were Egba; one, Ijebu; one, Ilorin, one from Lagos and one, Yoruba (of unknown town of origin); and two Hausa. (NAI, Lagos Annual Report, 1900-1901). The earliest form of treatment was with iodine, which was applied externally and iodide of potassium and hydreg perchloride used internally.

One of the teething problems associated with the leprosarium was the tendency of the inmates to abscond as three did in 1899. (NAI, Lagos Annual Report, 1899). This influenced Governor Alfred Molony's decision (with advice of the Executive Council) to proclaim an order declaring contagious disease hospitals as prisons on March 2, 1899, although it was not applied to lepers stringently (NAI, Lagos Annual Report, 1906). This order rested on Ordinance Number 9 of 1876, which empowered the Governor to do so. Going by the permissive nature of the seclusion policy, compulsory seclusion was difficult to enforce and Lepers could ask to be discharged against doctor's advice because many of them "preferred being in their own villages where they could plant garden products, make palm oil and rear poultry" (NAI, Lagos Annual Report, 1899). Some even preferred "begging for alms from the too indulgent public" (NAI, Lagos Annual Report, 1899). Segregation for leprosy patients was relatively loose until 1916 when the health authorities made more stringent rules. Further development, as we shall see, resulted in the establishment of more leprosaria in places like Ogbomosho and Ossiomo alongside a host of Native Authority leper camps across Western Nigeria.

Since compulsory detention was never effective, the policy adopted was to educate and persuade infected persons to avail themselves of the opportunities offered by the asylum. Vagrant lepers were not compelled by law to submit themselves to compulsory seclusion. Therefore, A. J. Broodie, then Colonial Surgeon lamented that the government was paying for an institution which certainly offered little protection for the general public and even the patients who often spoilt their treatment by lack of continuity of treatment. According to him; "The law or rather want of some law regarding lepers in the Colony of Lagos makes this institution…merely a casual ward for lepers, paupers, many of whom come and go as they please" (Broodie, 1901).

This scenario was replicated in the Onitsha Leper Settlement, which had commenced operation by 1909. There was a high rate on leprosy infection in the neighbourhood of Onitsha, including the Agbor, Asaba, Ibusa, and Ogwash-ukwu axis. Cases from these latter towns were initially handled at Onitsha, but subsequently at Ibusa, where a leper colony was opened in 1913. (NAI, Annual Report, 1913). A leper Ordinance was passed on 2nd September 1910 (NAI, Annual Report, 1910). It introduced a modified system of segregation by the establishment of leper settlements and villages with the paraphernalia of an agrarian community. The ordinance influenced the construction of the Ibusa settlement in 1913. In that year, Yaba had seventeen inmates, Ibusa, fifty-two and Onitsha, 100. Onitsha at that time, in spite of the Ibusa site, still accommodated several patients from Western Nigeria (NAI, Annual Report. 1913). The new Ibusa site operated as a small leper village. It was maintained by the "native community". Farmland was allotted to augment the food and clothing provided by the relatives of patients. Although the policy of farming was integrated into the leper settlement or village system, the planting of crops was not entirely a new idea. As far back as 1900 gardening was a part-time resort at the Yaba centre. Greens, banana, plantain, oranges, breadfruit were planted (Sapara, 1900). But a 1914 settlement policy emphasized a larger space, a more elaborate farm and location within a village in the neighbourhood of larger towns (NAI, Annual Report, 1914). Although these measures were already in place, an ordinance to further regulate the establishment of asylums and settlements for the isolation and detention of lepers was promulgated on 21st December, 1916. It streamlined the meaning of an asylum, defining it to mean "a place established by government for the temporary or permanent detention of lepers" while a settlement was taken to mean "a suitable number of native dwellings established and supported by government or by a native community for the isolation and detention of lepers" (Kingdom, 1958, p. 2188). Compulsory detention was still not rigidly adhered to at this point and had to wait until Order 47 of 1951 when it was declared that every person residing in a house…who knows or has reason to suspect that any innate therein is a leper, and every person who knows or reasonably

suspect that a person employed by him in a proclaimed district is a leper shall give notice thereof to the nearest magistrate (Kingdom, 1958). Defaulters at that point were made to pay a fine of five pounds.

In spite of these efforts, leprosy remained a virulent epidemic. In the 1920s, alepol, a variant of the chaulmoogra oil was introduced as the drug of choice. It produced impressive results and, therefore, inspired the expansion of leprosy control in western Nigeria (Browne, 1980). On January 31, 1924, the British Empire Leprosy Relief Association (BELRA) was formed. It became a powerful voice in the campaign against leprosy. Its influence was felt in the emergence of Ogbomosho and Ossiomo settlement in 1926 and 1931 respectively. Its leader Dr Ernest Muir visited Nigeria in May 1935 and made recommendations that were to form the basis of new arrangements. The influence of Muir and his BELRA intensified the involvement of Christian missions. In fact, Muir had recommended the expansion of the present system of settlement on a provincial basis and the policy of placing medical mission in charge of Native Administration leper colonies. (NAI, Annual Report, 1936).

The Ogbomosho and Ossiomo settlement became key players in the implementation of this policy. The construction of the Ogbomosho centre started in1926 and by 1935 it had become fully operational with fifty-five inmates under the aegis of the Baptist mission. The Ossiomo settlement was initiated in 1931 by a Catholic Lady, Dr Louba Lengauer, with the help of Rev. Fr. Hugh Colon (Schram, 1971). Grants were received from the Colonial Development Fund but the centre was to be jointly maintained by the Native administrations in Benin and Warri. It commenced operation formally in 1938 with a target population of 500 patients. By 1939, it had about 319 patients and 381 in 1940. Ogbomosho and Ossiomo centres, like the Yaba and Ibusa centres had farms which inmates cultivated to augment what the missions and Native Administrations provided (Shokpeka, 2008). The Ossiomo centre later became a model centre for the Western Region. It gave technical support to the Native Authorities that ventured into the construction of small leprosy camps which became common during the war years.

4. Leprosy Control during the War Years

By the beginning of World War II, in spite of the efforts of the past years, the problem of leprosy was still largely unsolved. The leprosaria at Ogbomosho and Ossiomo had, at best, laid a foundation, for leprosy work. There was still much to be done to develop such an institutionalised control system. Vast areas were still not attended to beyond the Benin and Yoruba axis that were relatively close to the administrative capital in Lagos. Leprosy control, for example, was absent in Urhobo and Isokoland. The marked the influx of the Urhobo people seeking admission into Ossiomo Leper Settlement was an indication that leprosy was rapidly 'progressing' in the division (NAI, Ugheli District I/1146, Minutes). Similarly, a report on Oyo Provinces and environ indicated that out of an estimated number of 10,000 lepers, 9,400 were still roaming the streets. Those in Ondo, Ogun and Ekiti areas were poorly catered for in temporary camps. The Ossiomo settlement was overwhelmed by the influx of lepers from the Benin and Delta provinces. Leprous soldiers were also to be treated for there. By 1940, its facilities were already utilised to full capacity just as it was in Ogbomosho. The health authorities, therefore, sought government approval and improved funding to expand, recruit more staff and rev up propaganda work. A decisive and well-funded programme was required, but the government was more committed to its administrative responsibility in this regard. It practically shrieked from taking up the financial burden of expansion.

The tone of war time fiscal policy of a limited financial involvement in non-war concerns reflected government position. The government maintained a quadripartite arrangement between it (represented by the Health Department), the Native Administrations, the missions and the British Leprosy Relief Association (BELRA). The government coordinated the activities of the other agencies, but within the war period, it broadened their level of involvement. As the other agencies became more involved, government intervention dimmed. So much so that BELRA had to recommend the appointment of a full-time Leprosy Adviser and a Leprosy Unit (made up of a Leprosy Adviser, Research Officer and Field Officer) to augment the waning services rendered by government. By 1941, the Leprosy Adviser had become an important resource person (NAI, Oyo Prof1/21BXIX, C. P. Walker). The Native Administration, missions and BELRA, more than the government, financed leprosy control projects. In order to ensure continuity, create an enabling environment and possibly further develop the settlements, the government increasingly got the leprosaria to rely on internally generated revenue. The Director of Medical Services confounded by the financial difficulties experienced in the settlements in the war period, made a point about the need for a legislation to be introduced under section 8(g) of the

Native Authority Ordinance, and No. 43 of 1933, to provide for the maintenance of lepers by their families (NAI, Oyo Prof I/218XIX H. M. F White). A similar position had earlier been taken at the Uzuakole settlement in Eastern Nigeria based on the recommendations of D. N. Davey, the Medical Superintendent of the Camp, that families of leprous patients should bear part of the cost of their treatment. At Ossiomo in Benin Province, the idea was also adopted, and for the first time, the administration, in 1941, verified the composition of the inmates in relation to their capacity to pay or be sponsored by their families. To the amazement of the officers and the camp Superintendent, many who hailed from wealthy families but related to some chiefs or clerks of the Native Administration office were smuggled into paupers' quota (NAI, Oyo Prof1/218XIX Report). It was no longer business as usual; such patients were promptly re-categorised as fee paying. The statement of account of the Ossiomo colony in the 1943/1944 financial year clearly illustrates the importance of such fees to the sustenance of leprosy control efforts in the war years. The total revenue for the period was £2,545:8:5, which was accumulated as follows:

Table 1: Sources of Finance for Ossiomo Leprosarium, 1943/1944

Source	Amount
Native Administration	£1,530:00
Paying Patients	£533:12:6
Farm Products	£65:4:13
Nigeria BELRA	£100:0:0
Education Department	£60:0:0
Miscellaneous	£16:0:0
London BELRA	£240:0:0
Total	£2,544 16 : 9

Source: *NAI. Ben Prof1/BP.1417. Ossiomo Leper Settlement: 158.*

The highest contribution came from the Native Authorities, but the £1,530 they contributed was pulled together from eight divisions, namely, Benin, Agbor, Ishan, Kukuruku, Ogwashi-Uku, Sobo-Ughelli, Jekri-Sobo (Itsekiri) and Kwale-Agbor. Their contribution going by a 1939 report were as follows:

Table III: Contribution of Divisions to Ossiomo Purse.

Benin	£400
Agbor	£135
Isahn(sic) (Ishan)	£150
Kukuruku	£50
Ogwashi-uku	£150
Sobo-Ughelli	£200
Jekri-Sobo	£200
Kwale-Agbor	£220

Source: *NAI. Ben Prof1/BP.1417. Ossiomo Leper Settlement: 1-11.*

The revenue so derived boosted Ossiomo's capacity to expand its facilities to accommodate more inmates. Thus, in spite of war-time financial difficulties, it was able to build "a court, an oil plant shed, store, dormitory for girls, dormitory for boys, two latrine for men, one incinerator, two houses for married people, a new rest house for visitors and rearranged the market place (NAI, Annual Report on Ossiomo, 1941, p. 70). The policy which approved of a more intensive family support for lepers was also embraced at the Ogbomosho colony. The District Officer of Ife-Ilesha had argued that the legislation was "quite in keeping with native law and custom" (NAI. Oyo ProfI/1032. Vol. II: Reply. p. 258). The legislation was to be enforced through the Native Courts. Just as it was at Ossiomo, the improvement in the revenue base of the Ogbomosho colony arising from expanded family support also facilitated expansion, to the extent that in 1944 alone "the colony's physical space was expanded", more crops were grown, a special food factory was established, old buildings were repaired, twenty new huts were constructed, three new latrines and three incinerators were erected, forty new pupils and three new teachers also joined the leper school (NAI, Oyo ProfI/1032. Vol. II, Reply, p. 902). Ogbomosho and Ossiomo colonies, invariably, acquired sufficient stature to undertake the supervision of ancillary leper camps that emerged in various locations in the region especially in the 1940s. The two colonies were officially designated the headquarters of such clan settlements that emerged (Ogbeide**,** 2015, March 3, Oral interview). The satellite clan settlements of Ogbomosho colony included those located in Lanlate, Iwo, Ede, Ejigbo, Oyo, Iganna and Shaki. Together, they had 445 lepers in 1944. An additional one was established at Shepeteri in 1945 and commenced operation with twenty-two inmates. The number of inmates in these centres was 498 by 1945 whereas the Ogbomosho colony alone had 434 (NAI, Report on Ogbomosho Leper Colony, 1944). The Ossiomo colony also supported a programme of expansion through satellite settlements which emerged in places like Ugboha and Urhonigbe in Benin province. With these, more lepers were taken off the streets and homes, with a concomitant effect of reducing the spread of the disease.

The clan settlements were manned by attendants employed by the Native Administration. The Medical Superintendents based at Ossiomo and Ogbomosho were the medical overseers. They paid regular visits, supplied medication and ensured compliance to good standard of hygiene. They collated the report of the attendants and relayed same to the provincial Medical Officer of Health, who, in turn passed the

information to the Director of Medical and Sanitary Services based in Lagos. One of the challenges which the leprosy control authorities had to deal with was the relative shortage and increased cost of drugs owing to the extra cost of shipping during the war. Chaulmoogra oil obtained from the hydnocarpus plant remained the drug of choice during the war. It was supplied from England to the medical store in Lagos, from where it was sold to leprosaria. The government came up with an import substitution measure by way of local cultivation of the hydnocarpus plants. A pilot project started in Benin where the plant was successfully grown (Ogbeide**,** 2015, March 3, Oral interview). The cultivation of the plant was introduced from Benin into Ogbomosho and Oyo in 1944 as an alternative source of the chaulmoogra oil (NAI, Oyo Prof I /218XIX. Report, 1944). This policy was endorsed and implemented enthusiastically with the support of the Native Administration and the Missions involved. Undoubtedly, the Catholic and Baptist Missions contributed significantly to the programmes and the survival of Leprosy service during the war years.

The former took charge of the day-to-day running of Ossiomo settlement as a missionary and humanitarian service, ensuring a steady flow of medical and clerical officers from its fold. Ossiomo jobs were regarded with disdain. The fear of becoming infected made them unpopular. Those who took up positions in the settlement were encouraged by the missions who preached that it was a virtuous and cardinal work of mercy to do so. At the Ogbomosho settlement, the Baptist Church was the partner. It encouraged its members to take up appointment and was involved in the running of the centre to such an extent that the Resident of Oyo Province could assert, unequivocally, that the "settlement at Ogbomosho is not a Native Administration settlement. It is a mission concern assisted financially by the Native Administration" (NAI. Oyo Prof I /218XIX. Resident Oyo). But it was subject to government control through a provincial board. (NAI, Oyo Prof I/218XIX. Resident Oyo). Although the government was ill-disposed to a heavy financial involvement during the war years, it never reneged on its role as a policy formulator. The Director of Medical Services in 1943 reiterated government policy position when he declared that

The development of leprosy control work on comprehensive preventive lines is far beyond the scope of the mission organisations to undertake. In any event, there are so many administrative, medical and public health problems involved, that responsibility for direction and maintenance must be undertaken by government, its continuity of policy is necessary to ensure permanent results is to be obtained (NAI, Oyo Prof I /218XIX. Report on Ogbomosho Leper Colony, p. 901)

Therefore, the government insisted that the Native Administration's contribution should continue. By 1945, the Baptist mission had become more deeply committed financially. It offered as much as 6000 dollars for the development of the camp, even expressing the desire to run the leprosarium independently as a sole financier. The government responded that the "mission was free to carry on its leprosy policy" but that the "general direction of policy must remain in the hands of the government" (NAI, Oyo Prof I /218XIX. p.901). For instance, it took the government to institute a regulation that leprous soldiers should be admitted and treated at the government's expense. Government approval was also required before leprosy patients were allowed to barter with healthy population in their neighbourhood and to regulate the degree of contact they should have with them. By soft-pedalling on leper-community business transactions, the leprosaria gained in revenue generation. But government position was rationalised thus:

It is not the policy of the leprosy service to cut off segregated patients completely from their people and relatives… for if they were harshly treated as prisoners, people would be reluctant to stay in the village…. The germ of leprosy which lived in the blood was only infectious through constant contact of body (NAI, Ugheli Dist I/1146. Minute).

Settlement-community relations required a lot of propaganda work. Sanitary inspectors spearheaded the work, with occasional visits by the propaganda unit and the sanitary superintendent.

Definitely, there is a lesson to be learnt from the contribution of the native authorities to the dispensation of preventive healthcare in Western Nigeria up to 1945. The role they played during World War 11 period, when government became less willing to finance non-war projects, unlike what obtains in contemporary Nigeria, demonstrates the capacity of local governments to operate as effective agents in preventive healthcare. Their financial contribution and improvisation saw several communities and preventive healthcare institutions like leprosaria through the vicissitudes and the financial crunch occasioned by the war.

5. Conclusion

The control of leprosy in Western Nigeria has a checkered history. As indicated in this study, the late 1880s up to 1945 could be regarded as the foundation years of leprosy control policies in the area as most of the modalities instituted for the purpose are traceable to the period. This study complements the works of Oduwobi and Manton whose scope of study began in 1926 and 1945 respectively because significant developments had been recorded before these dates. The government, Native Authorities, BELRA, Catholic mission, Baptist mission and families were engaged in the control of the disease. Although cure was sought through the administration of medicines such as iodide of potassium, hydreg perchloride and chaulmoogra oil, greater emphasis was placed on prophylactic isolation of leprous patients in asylums and leper settlements. A significant proportion of available funds was deployed to the construction and funding of the centres in addition to the upkeep of the inmates. This was the foundation built upon in subsequent years by WHO, UNICEF, post-independence Nigerian government, Nigerian Leprosy Mission (NLM), Non-governmental Organisations and the German Leprosy Relief Association (GLRA) which was established in 1957 and re-christened German Tuberculosis and Leprosy Relief Association in 2003.

The conditions of the leper settlements have deteriorated over the years. Some patients who have been healed and their children elect to remain in the settlements because of rejection by society. Some come out to the highways to beg for arms and even sell food items to travellers. The inmates and their families now practically fend for themselves. The poor attention given to leprosy control has made it impossible for the disease to be eradicated in Nigeria. Report by the Nigerian Centre of Disease Control indicates that over 3,500 people are infected with leprosy in Nigeria every year (Onyeji, 2021). This has earned the disease a place in the list of Neglected Topical Diseases (NTD) produced by WHO. There is a need, therefore, to explore the lessons inherent in the collaboration between the government, local governments, donor agencies and families to rekindle the drive towards the eradication of leprosy in Nigeria.

References

Browne, S. G. (1980). Leprosy. *Health in Tropical Africa during the Colonial Period*. (Eds, E. Sabben- Clare, D. J. Bradley and Kirkwood), New York: Oxford University Press. 76.

Kingdom, D. (1958). *The laws of the Federation of Nigeria and Lagos.* (Revised Edition). Vol. 4. Lagos: Federal Government Printers. 2186-2188

Oduwobi, T. (2013). Tackling Leprosy in Colonial Nigeria, 1926-1960. *Journal of the Historical Society of Nigeria.*22

Manton, J. (2003). Global and Local Contexts: The Northern Ogoja Leprosy Scheme, Nigeria, 1945-1960, *History; Historia, ciencia, saude-Manguinhos.*

Ogbeide, F. A. (2015). March 3. Oral interview. Former Director of Ossiomo Leprosarium from 1991 – 2010. Benin City.

Onyeji, E. (2021). World Leprosy Day: Inside Nigeria's 'neglected' Leprosy Community, *Premium Times*. January 31. www.premiumtimesng.com

Schram, R. (1971). *History of Nigeria Health Services.* Ibadan: University Press. 235

Shokpeka, S.A. (2008). *Local Government and Development, Perspective from Old Benin Province,1938- 1960* Benin City: University of Benin Press. 136.

Broodie. A. J. Asst. Colonial Surgeon. NAI, Annual Report, Medical, Department. 1901.

NAI. Yaba Leper Asylum. Lagos Annual Report. Medical Department. 1899.

NAI. Annual Report. 1899: 2

NAI. Oguntola Sapara, Medical Officer in Annual Report. 1900

NAI. Annual Report. Medical Department. 1900-1901.

NAI. Lagos Annual Report, Medical Department. 1906.

NAI. Annual Report, Medical Department. 1910.

NAI. Annual Report Medical Department. 1913.

NAI. Annual Report Medical Department. 1914.

NAI. Annual Report, Medical Department. 1936.

NAI. Annual Report on Ossiomo by Medical Superintendent, 1941. 70.

Sapara, O. NAI, Annual Report, Colony and Protectorate of Southern Nigeria. 1900-1901.

NAI. Isoko Federal Native Administration Executive Committee, 18/11/52. 4/41:69-70.

NAI. Oyo Prof1/21BXIX CP. Walker Acting Director of Medical Services to Chief Secretary of Govt., Lagos. 155.

NAI. Oyo Prof I/218XIX H. M. F. White, Provincial Office Oyo to the Senior D. O. Ibadan and D. Os of Ife, Oyo, Ilesha and Oshogbo.

NAI. Oyo ProfI/1032. Vol. II: Reply of the D. O. Ife/Ilesha to the Resident Oyo Province, 10/11/41. 258-902

NAI: Oyo Prof I /218XIX. Report on Ogbomosho Leper Colony. 1944. 898-901.

NAI: NAI. Oyo Prof I /218XIX. Report on Ogbomosho Leper Colony. 1944.

NAI. Oyo Prof I /218XIX. Resident Oyo to Sec Western Province 839 25/9/43.

NAI: Oyo Prof I /218XIX. Memo. J.W.P. Harkness, Director of Medical Service to the Senior Health Officer, Ibadan. 901.

NAI. Oyo Prof I.218XIX. Memo by Sec. Northern Province, 25/4/44. 555.

NAI. Ugheli District I/1146. Minute of the 7th Meeting of Urhobo-Isoko Federal Native Administration Executive Committee, 18/11/52.