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Fight against Disease of the Body to Safe Guard the Spirit: An Evaluation of the Joint Anti-Leprosy Campaign of Sudan Interior Mission (SIM) and Governments in Sokoto Area of Northern Nigeria, 1919-1975

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ABSTRACT

Leprosy is one of the dreadful diseases that are contagious and ghastly as well as stubborn and difficult to control. The disease has been prevalent in Nigeria for hundreds of years ago managed under traditional systems. However, modern control and prevention methods of leprosy disease began in the eastern part of Nigeria during British colonial administration of the area. Perhaps, the reason was that the region was believed to be the most endemic area of leprosy. The campaign was later extended to northern Nigeria in which the central Colonial Government, the Sudan Interior Mission (one of the strongest evangelical movement during colonial administration), and the Native Authorities made a joint effort to control and prevent the disease in the defunct Sokoto Province. This paper aims to examine the activities of the three bodies in the anti-leprosy campaign. As against somewhat general assumption, the paper shows the extent to which missionary anti-leprosy services was provided and appreciated in a predominantly Muslim community. It is discovered that Sudan Interior Mission in conjunction with the colonial and local authorities contributed significantly to the prevention and control of leprosy disease. This is with a view to create healthy bodies among the patients whose souls will be won for the Christ. While the Colonial government and the Native Authorities fought against the disease principally to safeguard the labor which their administrations needed most. This became the basis for the assumption that, common disease aimed to be eradicated for different goals but in harmony among the opposing actors.

Keywords: *Sudan Interior Mission, Native Authorities, Leprosy Disease, Anti-leprosy Campaign and Sokoto Area.*

INTRODUCTION

Leprosy disease is a chronic bacterial infection that primarily affects the skin mucous membranes (nose, eyes and testes). It is known as Hansen's disease and is one of the oldest diseases of mankind. Leprosy has different types depending on the stage of the disease. The two major types of leprosy are Lepromatous and Tuberculoid. The former is highly communicable and from the public health view point, the latter is less communicable.

According to Schram (1971), leprosy disease may have been introduced to the Nigerian area since 2000 BC, and it became most prevalent in the eastern and northern part of the country. In the pre-colonial period, the Yoruba and Igbo usually ostracized leprosy patients away and killed their victims' children to control and prevent the disease while the Hausa people of northern Nigeria showed far less fear for the disease. However, they still isolated the infected people from the larger society, though with little attention to the prevention of the disease. The conventional methods of leprosy control and prevention in Nigeria started during the colonial period. Precisely, the methods began to be applied to anti-leprosy activities in Sokoto Area in the late 1910s. Although the activities commenced before the arrival of the Sudan Interior Mission (SIM) in Sokoto, the SIM later dominated anti-leprosy campaign until when the Native Authorities (NAs) joined the campaign. By the end of the 1940s, the central Colonial Government joined the NA-SIM effort to control and prevent leprosy disease in the area. This chapter examines the role Government-NA-SIM anti-leprosy activities in Sokoto Area.

Study Area

Sokoto area under study refers to all the territories of the defunct Sokoto, Gwandu, Argungu and Yauri Native Authorities that were centrally administered by the British under Sokoto Province. The territories made up the present-day three states of Sokoto, Kebbi and Zamfara in north-western Nigeria.

The Origins of Anti-Leprosy Campaign in Sokoto Area

A survey in 1910 indicated that leprosy disease was one of the most prevalent diseases in northern Nigeria, especially in Sokoto Area. The survey indicated that the disease was so prevalent in Sokoto Area in which there were 5,381 lepers equal to 5 per thousand of the population of Sokoto Native Authority alone. However, serious attention was not given to the control of the disease. Campaigns against the disease began in Sokoto during the second decade of the colonial period and even then, little emphasis was given to the exercise up to 1950s. Generally, it was during the First World War period that a foundation to control leprosy disease was made in Nigeria. Leonard Rogers in India and Dr. Helser in the Philippines investigated the use of Chaulmoogra Oil in the treatment of the disease from 1914 to 1918. After the investigations, the substance was tested in Yaba (Lagos, Nigeria) and it proved effective. Consequently, some provinces in northern Nigeria began to use the oil in the treatment of leprosy. In Sokoto, leprosy treatment using the oil commenced in January, 1919. The first two treated patients were declared better and since then, nearly 35 lepers voluntarily submitted themselves for treatment twice every week throughout the year.

Moreover, another development in the anti-leprosy campaign came about shortly after World War I when the Reud "Tubby" Clayton, the founder of the TOC H Movement visited Nigeria. Thereafter the visit, TOC H. Volunteers arrived in northern Nigeria and started a leprosy settlement in Kano. Initially, it was thought that there were few cases of leprosy in the whole northern Nigeria, but as soon as the news of the hope of cure spread, thousands of patients were referred to the centre. Consequently, SIM led by Dr. C.W.J. Morris and J.A. Driestbach took the responsibilities. Henceforth, missions and NAs embarked on shared anti-leprosy services in segregation villages and settlements throughout the 1930s and 1940s. The NAs and SIM made a joint effort in anti-leprosy work and established three Provincial Leprosy Settlements (PLSs), each in the provinces of Kano, Katsina and Sokoto. In the case of Sokoto, Amanawa PLS was established in 1940. Henceforth several segregation villages (SVs) and out-patient clinics (OPCs) were established. The SIM and the NAs agreed in principle on how to manage the activities of the established leprosy treat ment centers. The following section is on the SIM-NAs' Agreement.

Native Authorities and the SIM Agreement in Anti-Leprosy Campaign

There was an agreement drafted in 1942 between the NAs of Kano, Katsina and Sokoto Provinces on the one hand and the SIM on the other in anti-leprosy services. The agreement was a guiding principle on how the services should be run and it provided that the NAs had to contribute to the maintenance of the PLSs. The contributions were: of a certain amount weekly for the maintenance of each person living with leprosy in the PLSs, a contribution to the cost of drugs, NAs should bear the cost of erecting and maintaining any school building in the settlements. They should also bear the cost of erecting and maintaining huts for the accommodation of leprosy patients among other responsibilities. The SIM on the other hand was responsible for the cost of diets, beddings, clothing, disinfectants and any drugs required in addition to those provided by the NAs; provided that could not preclude the grant by the NAs to the Mission. Similarly, the SIM had always to maintain an adequate staff including a licensed medical practitioner, a certified nursing sister, a camp superintendent and such general and sanitation laborers as may be necessary to maintain the settlements in a satisfactory state.

Central Colonial Government and the Policies of Anti-Leprosy Campaign

This section deals with general policies of the campaign against leprosy disease since 1945 when the Colonial Government began to give its attention to the control of the disease. It began with the first Government Scheme on Leprosy Control when the head quarters of the Government leprosy services was created in Oji-River, Enugu Province in eastern Nigeria. The scheme provided that, there had to be in each province a PLS of not more than 1,000 patients. Capital Grants were provided to PLSs from the

Colonial Development and Welfare Fund (CDWF) for the construction of a hospital, water supply and patients' quarters in each PLSs. The PLSs was officially made the centers of the organization in anti-leprosy services to which infective cases were also referred. SVs and OPCs were on the other hand designated for the treatment of less infective. The Medical Officers in-charge of PLSs became in-charge of all leprosy services in their respective provinces. They were before 1956, responsible for the supervision of all the SVs and OPCs under their areas. There should be ideal medical supervision after every three months on the isolated infective lepers, in which every inmate had to be inspected. There had to be a leprosy attendant at each SV, who was supposed to look after the patients regularly.

The policy was revised in 1950 and it made a distinction between the two cases of leprosy for segregation and out-patient treatment. Most importantly, the review of the policy provided a network of rural control services in SVs and at OPCs as well as training of leprosy inspectors for rural anti-leprosy work. NAs were encouraged to provide SVs so that the patients of those communities can have easy access to regular treatment and infectious cases had to be directed to PLSs. On the issue of running leprosy treatment institutions, the Colonial Government was unable to recruit the needed personnel for the staffing and supervision of the institutions. Thus, the missionaries already undertaking leprosy services were invited to cooperate with the Government in the services and their work was subsidized. The subsidies were: Capital Grant for construction of institutions and Recurrent Grant for running the institutions. The missions acted as agents of the Government and the NAs in the management of PLSs and SVs.

Hence forth, the missions continued to cooperate with the Government and the NAs. Mean while, a new policy came to effect in 1952 that entailed the necessity of reducing the size of PLSs by transferring cases that did not necessarily required treatment at the settlements to SVs. This was to reduce the work in the PLSs and thereby to free the doctors to devote time to the inspection of SVs and OPCs. It was also intended to save the funds spent on the subsistence of such patients to develop hospitals and laboratories as well as train and pay the salaries of the staff in the PLSs.

For the implementation of the policy on leprosy control in Sokoto Area, there was a distribution of duties between the Government and the NAs in which the latter became responsible for rural services. In this regard, the NAs had to provide and staff several SVs and OPCs. Concerning urban services, Government in conjunction with SIM had to continue to maintain Amanawa PLS. Moreover, apart from SVs and OPCs, the NAs had to contribute to the maintenance of Amanawa PLS equally.

However, the most significant Government policy on leprosy control was that of 1954. The policy was in preparation for taking over the supervision of treatment centers from the Missions by the Government staff in 1956. Similarly, an emphasis was placed on OPCs than segregation in SVs and PLSs. This was made possible by the effectiveness in the use of Daps one tablets. Before the discovery of Daps one in 1940, leprosy treatments were made using Hydnocarpus oil with uncertain results, and the disease continued although in a milder form.

In the meantime, the use of Daps one revolutionized the treatment except in the acute infectious type, as it checked the disease within a short time and brought relief in a few weeks. Thus, in most cases, treatment with Daps one made segregation unnecessary; and the policy emphasized that OPCs should spearhead anti-leprosy work. Consequently, efforts had to be directed to increase the number of OPCs so that, by using Daps one and minimal segregation, leprosy could be attacked in an early stage before open stages were established. Furthermore, about taking over the supervision of leprosy services, the policy became effective with the formation of Government Leprosy Control Unit. With the rapid increase in the number of OPCs, the issue of supervision became increasingly onerous, and the mission doctors, who hitherto supervised the clinics, could no longer continue with it.

Similarly, Government staff had increased to cope with the situation. Thus, the take-over of the supervision became possible by the Government staff. Specifically, it is observed that the foregoing policies had the following main aims: propaganda and education of the public about leprosy disease; provision of treatment; provision of facilities for isolation of

the infective lepers; survey of the entire population with regard to leprosy infection; isolation of infective patients; and above all coordinated Government-NA-Mission anti-leprosy services.

Government, N as, SIM and the Management of Leprosy at Amanawa PLS

Amanawa PLS was established in 1940 as the headquarters of leprosy control organization and referral centre for the leprosy Segregation Villages. The settlement began with forty houses, stores and isolation ward with 32 beds. Dr. Payne was the first Superintendent of the settlement until October, 1941 when he was relieved by Dr. Morris. There was SIM industrial supervisor, one qualified nursing sister, a welfare worker responsible for the care of the children and the wife of the super intendment, looked after the crèches. By 1941 there were 169 resident patients in the settlement.

The number of inmates kept on increasing and by 1948 there were 276 patients in the PLS. Mean while, the Sokoto NA gave £1,000 as reimbursement to construct 10-bed ward in the settlements' hospital in 1949. The NA desired that Muslim children should be in principle separated at an early age from leprosy parents; therefore, it provided £800 for the construction of Babies' Crèche in 1949. Sokoto NA continued to assist the SIM in the maintenance of the crèche after the construction. Similarly, in 1949, the SIM provided £330 for sanitary structures, repairing of huts and construction of new huts at Amanawa. Finally, on the eve of its take-over by the Government, there were 250 patients at the settlement. The Sokoto NA provided £200 for new sanitary structures and huts and £130 for the repairs of the existing ones. By 1950/1951, after the take-over of the settlement by the Government, all the NAs' responsibilities as enshrined in the SIM-NAs' agreements were handed over to the Government.

However, NAs continued to make contributions to the development of the PLS. This was because in most cases, the Government Grants for the maintenance of the settlement were not enough. For instance, during the meeting of the Sokoto Leprosy Board in 1953, Dr. Grant and Mr. Legg complained that the years' grant (1952/1953) was not adequate for the re-roofing of patients' huts. In order to complete the re-roofing of the huts, the NAs in the Area gave the following grants: Sokoto NA £120, Gwandu NA £40 and Argungu NA £20. Concerning subsistence to patients, the Government also took over the responsibility from the NAs. However, according to Dr. Ross, Government had been unable to provide funds on the same scale as previously provided by the NAs. Ross added that he had appealed repeatedly for more funds, but it was not obtained. Consequently, the NAs continued to give subsistence money to their respective patients at Amanawa. For instance, in 1951/1952 Sokoto NA spent about £2,324 on 325 patients in the year. Similarly, in the year 1952/1953, the NA provided £2,860 for her 400 patients in the settlement. Also, the NA gave 15 tons of grains for her patients in the same financial year. Furthermore, the settlement kept on improving structures and medical services up to 1960. Regarding infrastructural development, there were new buildings of nineteen huts and pump house in 1954/1955. Similarly, in 1955/1956, there were the extensions of four rooms to Girls' Welfare Section and new women compound unit of eight rooms. In 1959/1960 also, twenty round cement and stone houses were built to replace mud huts. With regard to medical services, there were 277 and 193 new admissions as well as 45 and 65 surgeries in 1954-1955 and 1955-1956 respectively. Likewise, there were 385 inmates in 1956/1957 and 261 new admissions with 55 surgeries in 1958/1959. Finally, in 1959/1960, 110 patients were admitted and 15 operations were carried out. With the attainment of independence, the settlement continued to be under the Northern Regional Government and the SIM. It continued to give medical services beyond the confines of leprosy patients. In 1960/1961, for instance, there were 310 admissions, six deliveries (childbirth) and 83 operations. Also, with the creation of north-western State in 1967, the settlement became under State Government-SIM control. However, it was taken over by the Government on the 1st of April, 1975. By this time there were 235 patients at the settlement. Apart from leprosy services, there was the treatment of 789 other diseases at the settlement's hospital between April and May of 1975.

Government, N as, SIM and the Management Leprosy at Segregation Villages

It was made clear earlier on that during the 1950-1955, Leprosy Control Policy, NAs were responsible for the establishment and maintenance

of SVs and OPCs. Thus, some SVs were established by the SIM with NAs' grants while others were established and maintained by the NAs alone. The major role of the SIM in the management of SVs was professional supervision, although in 1956 Government relieved the SIM from such burden. Apart from the NAs' Grants to the SIM for the establishment of SVs, the NAs also gave a lump sum of money to the SIM for the running of the villages. For instance, the NAs as shown in the table below contributed the followings during 1952/1953 and 1953/1954 for the running of SVs.

Table1. *NAs' Contributions to the SIM for the Management of SVs between 1952 and 1954*

	1952/1953	**1953/1954**
Sokoto NA	£2,000	£1,800
Gwandu NA	£260	Nil
Argungu NA	£140	£10
Yauri NA	Nil	Nil
Total	£2,400	£1,810

Source: *NAK/SOKPROF/8296/Leprosy Control Scheme*

Moreover, the NAs were responsible for the transport of patients requiring treatment at Amanawa from SVs and their subsequent return to the SVs. Consequently, the NAs in the area contributed £1,500 for the purchase of an ambulance for that purpose. The NAs were also responsible for local staffing of SVs and OPCs. Some people were sponsored by the NAs to undertake a course of training in leprosy management at Medical Auxiliaries Training School, Kaduna. The government, on the other hand, provided senior service staff for supervisory purposes. Regarding the establishment of SVs, the first of such centers with a capacity of accommodating 15 lepers was established in Argungu since 1935. This was followed by Gummi SV established in 1950 by the Sokoto NA. Gummi SV was intended to accommodate 50 patients, but more than 100 lepers were obtained. Consequent upon its success, additional SVs were established in Moriki and Kalgo between 1952 and 1954 by Sokoto and Gwandu NAs respectively. Prior to 1956, the NAs in the Province were responsible for the purchase of drugs and dressings for the care of lepers in the villages. For instance, for each SV, the NAs gave a recurrent grant of £150 per annum to the SIM for the purpose. In addition, the NAs provided farming land in each of the villages for the inmates to support themselves. However, in a situation where the inmates could not farm, the NAs arranged for such emergencies. For example, Sokoto NA stored a large number of grains for the feeding of such inmates in its SVs. Moreover, the other NAs of Gwandu and Argungu took responsibility for the sustenance of such inmates. There was also artisan training of lepers in the villages. The NAs employed those who got training. By 1956, when the Government decided to take over the supervision of the villages from the SIM, there were already four SVs, one in each of Gwandu and Argungu NAs while two were in Sokoto NA. There seems to be no evidence of the existence of any SV in Yauri NA. This could have been because Yauri was comparatively a less leprosy-endemic area as its climate was unfavorable for the disease. All the SVs in the Area except Argungu SV were under the supervision of the SIM. The SV at Argungu was supervised by the Rural Medical Officer of the Government Rural Health Centre at Argungu. After the take-over of the supervision by the Government, the NA continued to maintain the villages. The villages remained four and Gummi SV had been the best up to 1960s. For example, by 1961 the patients in the village doubled the inmates in each of the other villages with 350 residents. By 1971, there were 700 patients in the four villages. The SVs continued to be managed by the NAs in collaboration with SIM until 1975 when most of the missionaries left the Province. For instance, Phyllis I. Lawson (Miss) was in-charge of SV at Kalgo up to 1975.

The Management of Leprosy Disease in Out-Patients' Clinics

According to the Leprosy Control Scheme of 1950-1955, OPCs were organized for the treatment of "closed cases" through dispensing Dapsone tablets. The establishment and maintenance of OPCs was the NAs-SIM joint responsibility even though in quite a number of instances, Government established OPCs. OPCs began to be established firstly in Argungu NA before the development reached other NAs in

Sokoto Area. It all started when SIM declined to supervise an SV in Kamba, and instead the SIMs' NS in-charge of Kamba opened an OPC in the area. The clinic commenced operation under the supervision of Dr. Grant (SIM, Senior Medical Officer Leprosy Control) in 1953. In the same year, another OPC was established by the Government and attached to the RHC Argungu. The first OPC established outside Argungu NA was in Moriki by Mr. and Mrs. D.B. John of the SIM in 1953.

Moreover, Northern Regional Government established three more clinics in Argungu NA in 1954 and about 500 lepers received treatment at the clinics in the year. Again, another set of OPCs was established in the year as shown in the table below:

Table2. *The Date of Opening Some Government and NAs' OPCs as well as their Patients on Register and the Number of Patients Attending by 1954*

S/No.	Clinic	Month	Number on Register	No. attending satisfactorily	Ownership
1	Argungu	January	59	49	Argungu NA
2	Gwandu	February	120	90	Gwandu NA
3	Gulma	February	31	24	Government
4	Bunza	February	44	38	Gwandu NA
5	Tambuwal	March	31	23	Sokoto NA
6	Kangiwa	March	32	22	Argungu NA
7	Yeldu	September	21	Nil	Government
8	Augie	September	NA	NA	Government
9	Yabo	March	220	200	Sokoto NA

Source: *NAK/SOKPROF/8296/Leprosy Control Scheme*

What is clear from the Table is that Argungu area was widely covered regarding leprosy out-patient treatments. More clinics continued to be established in the Sokoto Area and by 1955, 7,029 patients were attending the 32 clinics in the Area. As the number of clinics increased, the Government of northern Nigeria became committed in the supply of Dapsone tablets to both NAs and SIM clinics at no cost. However, a serious step towards the development of OPCs in Sokoto Area was made in 1956. This was the period when Dr. Ross visited Sokoto and recommended that all the NA dispensaries should run a weekly leprosy clinic. The treatment was to be given by Dispensary Attendants under periodic supervision of the Ross himself or one of his staff posted to the area. Consequently, quite a few NAs' OPCs were opened and attached to the existing dispensaries. By 1958, there were 33 OPCs in Sokoto NA as well as 17 and 9 clinics in Argungu and Gwandu NAs respectively; while Yauri NA had only 1 OPC at Yelwa. Likewise in the same year, there were 8 SIM leprosy clinics. Moreover, the SIM and the NAs continued to manage leprosy disease at OPCs up to the post-colonial period. By 1961, there were 107 leprosy clinics in the area, with 24,377 registered patients. However, based on the numbers of the clinics and the registered patients vis-a-vis the number of lepers in the Sokoto Area, there was still a great need for the extension of leprosy clinics and the employment of more staff by the NAs. The situation was further exposed by the UNICEF estimate that showed a total of about 62,000 cases of leprosy in Sokoto NA alone out of which 14,000 were with disability and only 10,000 of all were recorded under treatment. It was comparatively the worst NA in the Sokoto Area and the Northern Region as a whole. This brought about the need for vigorous propaganda and effort in the anti-leprosy campaign through a network of efficiently supervised OPCs. Consequently, quite several additional clinics were established and leprosy patients now either persuaded or enforced to attend treatment at the clinics by the traditional rulers. By 1966, there were 163 OPCs with 23,048 total patients in Sokoto area. Moreover, the number of clinics reached 177 with 28,232 total patients in 1968. The Dapsone tablets consumed in the year were 1,504,483 and 26 more clinics were established in Sokoto NA alone. The clinics continued to increase in number and by 1975, there were about 288 OPCs in the area

CONCLUSION

It is clear from the foregoing that, much had been done from the 1940s when Amanawa PLS

was established to 1975 when there were about 293 leprosy treatment centers in the Sokoto. Province. It must be acknowledged that much had been done that could not have been accomplished without the assumption by the SIM of the responsibility for leprosy work. Leprosy work from the 1950s became a joint effort in which the central Colonial Governments, the NAs and the SIM made steady progress. Therefore, the roles of all the parties involved in the provision of leprosy relief to patients must be appreciated. However, shortages of staff stood to be the challenging hitch to the progress of anti-leprosy services in the Area especially with the departure of SIM members in 1975. Finally, the position of the paper is that missionary medical activities were appreciated. Further, both the Christian evangelical body, SIM and the Governments, Central and Native Authority, recorded a significant success in the direction and goal aimed to be accomplished through the Leprosy Control. Almost all the Christian converts from Islam to Christianity in the Province were made through the Leprosy campaign. Governments, on the other hand, were able cure the already afflicted abled men and women and provided protection to the susceptible ones, thereby protecting the workforce. The joint action and alliance of trio was a rewarding and efficacious pact and coalition.

Key:

NAK= National Archives, Kaduna

SOKPROF= Sokoto Provincial Files

WJHCB= Waziri Junaidu History and Culture Bureau, Sokoto

AHK= Arewa House Archives, Kaduna

SIM= Sudan Interior Mission

REFERENCES

[1] Leprosy is named Hansen's disease after G.A. Hansen, who in 1873 discovered bacillus Mycobacterium Leprae, the virus that causes of the disease.

[2] NAK/SOKPROF/C.254/LeprosyControl/Leprosy Matters in General and NAK/SOKPROF/ C.74/Mission Medical Work/ SIM Leprosy Work, 1939-1951.

[3] AlhajiAbubakarDandare, 73 years, former Colonial Leprosy Assistant and later Health Inspector of Argungu NA, 23rd Sept. 2015. *Interview.*

[4] NAK/SOKPROF/C.254/Leprosy Control Matters in General.

[5] R. Schram, 1971. *A History of Nigerian Health Services,* Ibadan University Press, p161.

[6] R. Schram, *a History of the Nigerian Health Services...*p161.

[7] NAK/SOKPROF/70/1919/Sokoto Provincial Annual Report of 1919.

[8] NAK/SOKPROF/70/1919/Sokoto Provincial Annual Report of 1919.

[9] NAK/SOKPROF/70/1919/Sokoto Provincial Annual Report of 1919.

[10] R. Schram, *A History of the Nigerian Health Service* ... pp161-189.

[11] NAK/SOKPRO F/70/1919/Sokoto Provincial Annual Report of 1919.

[12] R. Schram, *a History of the Nigerian Health*... pp189; 231; 303; 427 and 431.

[13] NAK/SOKPROF/C.74/Mission Medical Work /SIM Leprosy Work, 1939-1951.

[14] NAK/SOKPROF/C.74/Mission Medical Work/ SIM Leprosy Work, 1939-1951.

[15] NAK/SOKPROF/C.74/Mission Medical Work/ SIM Leprosy Work, 1939-1951.

[16] NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters in General.

[17] NAK/SOKPROF/8296/Leprosy Control Scheme.

[18] Nigerian Branch, British Empire Leprosy Relief Association, 1928. *Leprosy Relief Work,* Printed by the Government Printer, Lagos, and pp30.

[19] NAK/SOKPROF/6337/S.2/Leper Segregation Village Argungu Division.

[20] NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters in General.

[21] NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters in General.

[22] NAK/SOKPROF/8296/Leprosy Control Scheme.

[23] This happened after it was discovered by leprosy touring officers that quite many less infective and closed cases were admitted in the PLSs and their admissions made the running of the settlement very expensive. NAK/SOKPROF/8296/Leprosy Control Scheme.

[24] NAK/SOKPROF/TOU/22/Inspection Notes of M.O; S.M.O; Residents, etc.

[25] WJHCB/MED/2/II/SOKPROF/Development of N.A. Dispensary and Hospitals in Sokoto.

[26] NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters General.

[27] NAK/SOKPROF/8296/Leprosy Control Scheme.

[28] AHAK/SNP/19/23/A.395/Annual Report of the Ministry of Health Northern Nigeria for 1955/ 1956. R. Schram, *a History of the Nigerian Health* pp427 and 431.

[29] AHA/SNP/3/2/10/Sudan Interior Mission and Leprosy Work in Kano, Katsina and Sokoto and NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters in General

[30] NAK/SOKPROF/5751D/Medical Department Sokoto Annual Report for 1941.

[31] AHA/SNP/3/2/10/Sudan Interior Mission and Leprosy Work in Kano, Katsina and Sokoto and NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters in General.

[32] Babies' Crèche was used for accommodating healthy babies who were segregated from their parents. The method was that babies were segregated and their mothers did not have contact with them except at feeding hours, and every precaution was taken to prevent the infection of the infants through the contact. Not only in Sokoto or Northern Nigeria, but it was also all over Nigeria that the method was satisfactory and it had been found out that the health of infants and mothers was better when the method was adopted. However, in 1953 a practice of feeding infants in the Crèche began in Amanawa Leprosy Settlement.

[33] WJHCB/SOKPRO/MED/27/Amanawa Leper Home (Hospital), 1946-1956.

[34] NAK/SOKPROF/8296/Leprosy Control Scheme.

[35] WJHCB/SOKPRO/MED/27/Amanawa Leper Home (Hospital), 1946-1956.

[36] NAK/SOKPROF/8296/Leprosy Control Scheme.

[37] NAK/SOKPROF/8296/Leprosy Control Scheme.

[38] WJHCB/SOKPRO/MED/27/Amanawa Leper Home (Hospital), 1946-1956.

[39] AHAK/SNP/19/23/A.392/Annual Report 1963-1964/Ministry of Health Northern Nigeria.

[40] WJHCB/SOKPROF/MED/14/Sokoto Home of Treatment for Leprosy; Sudan Interior Mission Annual and Half Annual Reports and WJHCB/SOKPRO/MED/27/Amanawa Leper Home (Hospital), 1946-1956.

[41] WJHCB/SOKPROF/MED/14/Sokoto Home of Treatment for Leprosy; Sudan Interior Mission

[42] WJHCB/SOKPROF/MED/27/II/Amanawa Leper Home (Hospital) 1955-1975.

[43] NAK/SOKPROF/8296/Leprosy Control Scheme.

[44] AHAK/18/23/A.396/Annual Report of Ministry of Health Northern Region for the Year 1955-1956.

[45] AHAK/SOKPROF/SNP/19/23/A.397/Annual Report of the Ministry of Health Northern Nigeria, 1960.

[46] NAK/SOKPROF/FILENO.3858.

[47] NAK/SOKPROF/8296/Leprosy Control Scheme.

[48] WJHCB/NA/MH/SEC/001/Termination of Staf f General Hospital Reorganization 1963-1963.

[49] NAK/SOKPROF/8296/Leprosy Control Scheme.

[50] WJHCB/SOKPROF/MED/14/Sokoto Home of Treatment for Leprosy; Sudan Interior Mission WJHCB/MED/2/II/SOKPROF/Development of N.A. Dispensary and Hospitals in Sokoto.

[51] NAK/SOKPROF/TOU/22/Leprosy Control Inspection Notes.

[52] WJHCB/NA/MH/SEC/001/Termination of Staff General Hospital Reorganization 1963-1963.

[53] WJHCB/MED/46/Missionary Permit to and Selected Drugs Missionary Work.

[54] NAK/SOKPROF/6337/S.2/Leper Segregation Village Argungu Division.

[55] R. Schram, *a History of the Nigerian Health Services*...p36.

[56] NAK/SOKPROF/6337/S.2/Leper Segregation Village Argungu Division.

[57] WJHCB/MED/46/Missionary Permit to and Selected Drugs Missionary Work.

[58] AHA/19/12/A.12/ Provincial Annual Report 1954.

[59] Argungu NA established this and attached to the segregation village outside Argungu town. It should not be confused with the first one established by the Government and attached to the R.H.C.

[60] AHAK/SNP/19/2/A.12/Provincial Annual Report, 1954.

[61] NAK/SOKPROF/8296/Leprosy Control Scheme.

[62] WJHCB/SOKPROF/MED/34/Leprosy Clinic SIM Jega 1955-1955.

[63] WJHCB/SOKPROF/179/S./Leprosy Treatment and AHAK/SNP/19/2/A14/ Provincial Annual Report, 1956.

[64] NAK/SOKPROF/C.254/Leprosy Control/ Leprosy Matters General.

[65] AHAK/19/2/ A.16/Provincial Annual Report for 1958.

[66] NAK/SOKPRO/896/Leprosy Control Scheme

[67] WJHCB/SOKPROF/BCD/10/Gusau Hospital Extension 1955-1959.

[68] AHAK/SNP/19/2/A.19/Provincial Annual Report, 1961.

[69] WJHCB/SOKPROF/15/5/46/Leprosy Control Annual Report Half Year.

[70] WJHCB/NA/MH/011/S.10/Touring Reports of Leprosy Superintendant Rural Health

[71] WJHCB/SOKPROF/15/5/46/Leprosy Control Annual Report Half Year.

[72] T.O. Fadayomi, 1980. "Sokoto State: A Survey of Resources for Development", Nigerian Institute of Social and Economic Research, Ibadan, Prepared with the assistance of Nath Iheanacho and Pat OnyeKwuluje, March, pp92-3.

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