Caring or Curing?

Social Practice and Narration of Leprosy Work in Colonial East Africa

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In 1946, the American-born writer and foreign correspondent James Negley Farson, who was living in Cape Town at that time, published a review of a medical handbook in the Royal African Society's journal *African Affairs*. The handbook was authored by the South African doctor Michael Gelfand and bore the title *The Sick African*. Farson remarked that, for him as medical layman, the book's "real reward" was "that it will help to ease the sufferings, and save the lives, of an ever-increasing number of his fellow-men":

> I can see the White Fathers, up at Kabgaye in Ruanda-Urundi, studying it eagerly in the evenings, or a Tanganyika doctor referring to it, when he starts to diagnose the symptoms of a Native who looks as if he had malaria – or what? It is that kind of book; a hand-book, destined to lie upon the table *of doctors, nuns, priests, medical-missionaries, colonial administrators*; in fact, *every white man and woman working in Equatorial Africa, who has to treat the sick African*. And it is a book that would be of great value to the average Britisher, if only you could get the people at home to read it; it might *shock* them out of their dangerous indifference about the *obligations of the British Empire.* (Negley Farson 1946, 49; emphasis added)

Farson's remarks put a spotlight on the continued cultural and racial stereotyping of the colonial discourse on public health. Empire is cast as a two-body-problem: "white" men and women on the one hand and "the sick African" on the other, revolving around each other at a distance, but bound by the invisible forces of empire. Colonial public health is presented as an endeavor that assembled "white" experts of all kinds: scientific, religious, and political. In stark contrast, the alleged object of the joint effort remained in the collective singular, "the sick African." Of course, this "African" was a fellow-man, but very distant, almost as if "he" was living on another planet. Even if the medical handbook had originally intended to focus sick Africans as opposed to healthy ones: the journalist's eye did not miss the opportunity for a telling *pars pro toto.* He was quick to conflate "the sick" African individual with Africa

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as whole. Moreover, Farson wrote, the medical handbook of more than 800 pages in length had some lessons in store for the general British public at home, with the potential to "shock" them out of their "indifference" and remind them of the "obligations" of an Empire (Negley Farson 1946, 49–50). These are Farson's readings. Yet, the medical text yields itself easily to such spin-offs. Patients are always referred to in the colonial collective singular, being "the African," or "the native." The whole book appears as an exercise in cultural boundary work. It continuously employs a comparative gaze, holding a supposedly "white" or "European" experience of disease against an "African" one (Gelfand 1957).

Farson's brief review takes a wide gap in a bold stride. He bridges the divide of the cultural and the scientific with great ease. Farson distilled (or fabricated) a grand narrative from a voluminous medical handbook, projecting racial differentiation between "white" doctors and "native" patients, objectifying Africans as carriers of disease, conjuring up a diverse community of white experts to face health crises. According to Farson, the practical notes on diagnosis, therapy, or prevention addressed colonial practitioners on the ground. The grand narrative of colonial public health targeted at a much broader audience. It addressed the citizens of empire at home and abroad, thereby bridging another big gap, the one between the colonies and the metropole.

This chapter takes up some these implicit propositions. It examines non-fictional accounts of medical doctors, colonial officials, and missionaries in terms of their narration. Beyond and beneath the immediate descriptive and factual claims about colonial health, spatial connections and narrative plots become apparent, as well as the framing techniques with regard to events, actions, or agents. I focus on those textual moments, in which diseases become metaphors or even agents in a story, or in which patients as well as colonial medical practitioners are transformed into characters who play the roles of heroes, victims in distress, and antagonists, or, on the contrary, when crucial social agents transform into flat stock characters.

Factual texts claim to represent reality and truth. They are supposed to be adequate depictions of actual events, social formations, people's actions, or material effects (for example of diseases, microbes, unhealthy environments). Historians ought to take these claims seriously and need to go beyond examining them as pro forma. They will have to ask: what do these factual texts do to alter the social and material event that they claim merely to represent? How – by which means and to what effect – do they recreate and transform such events? To answer these questions a historiographical examination of narrativity will involve engaging with the social and material realities of the narrated events. Yet, these events can only be recreated as history through the analysis of factual representations (written, oral, graphical). Thus, contrasting social reality and its narrative transformation is rather less a clinical operation and more of a thought experiment.

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The aim of this chapter is to show how colonial public health is narrativized. Why would this be important for our understanding of historical change? Here, I follow the thinking of Stuart Hall who proposes that modern societies experience social reality mainly encoded as mass media narratives (Hall 1984; 2006). In addition, social and narrative realities are mutually entangled. Social and material events are constantly processed (encoded and decoded, as Hall put it) into stories and received as such in society. These broadly distributed narratives provide the basis of very material decision-making in society, for instance about who is allocated funds, who has the right to move across borders, who is to be cured or cared for, and in which way.

The leprosy eradication campaign of the 1920s through the 1940s is a suitable historical case to study narration in the field of colonial public health (Worboys 2000). The colonial medical experts who engaged in the campaign believed that they had found an effective cure for this archetypical infectious disease: regular (intravenous, intramuscular, or subcutaneous) injections of an oily substance derived from the Indian chaulmoogra plant (*hydnocarpus wightianus*). The *British Empire Leprose Relief Association* (BELRA) campaigned among colonial administrations, the British public and existing anti-leprosy initiatives to take up the new curative treatment. BELRA put forward the idea of eradicating the disease through drug therapy, rather than containing it by isolating and providing care for the infected. Most of the existing initiatives were rooted in Christian missionary work. BELRA offered them funding to build infrastructure and treatment with chaulmoogra oil preparations. By the mid-1930s, it became increasingly doubtful whether the chaulmoogra oil injections were actually effective enough to end leprosy. As a consequence, the eradication campaigning petered out in the following decade. More effective multi-drug-therapies against the disease became available only in the 1960s and 1970s and were adopted by the World Health Organization (WHO) in 1981 (Riha 2004). Currently, the WHO registers leprosy as a *Neglected Tropical Disease* and has issued a global strategy to eradicate leprosy by 2030 (WHO 2017).

As a case study, this chapter concentrates on leprosy work in Southern Tanzania between the World Wars, and analyzes health reports assembled by BELRA medical experts, Catholic mission doctors, as well as missionary priests and nuns. The narratives in these texts are put into relation with the social realities within and around a Catholic mission's leprosy settlements including the active participation, negotiating, and resistance of African patients. It is through these relations that the social productivity of narration becomes tangible.

The argument of this chapter develops in four steps. The first is a brief reconstruction of leprosy work in Southern Tanganyika during the 1920s through the 1940s. The second addresses the grand narrative(s) of colonial public health in a spatial sense as exercises in *connecting* and *scaling*. This step, as well as the following, will afford comparing religious and secular variants of narrating colonial public health. This distinction is not always clear-cut: Marcel Dreier provides an instruc-

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tive account on the difficulties of medical doctors attempting to fit into existing missions and their outlooks on conversions and care work in East Africa (Dreier 2015, 179–224; on medical missions, cf. Ratschiller 2023; Ratschiller/Weichlein 2016; Grundmann 2014; Hölzl 2011). Thirdly, I will discuss the impact of the *materiality of leprosy* on narration in an attempt to open the circle of possible authors and characters to include the *Mycobacterium leprae*. Fourthly, I focus on a particular group of agents within the network of leprosy work who shaped leprosy policies in local settings and were frequently the topic of reports but had hardly any access to the reporting process: African leprosy patients.

Negotiating Leprosy in Colonial Settings: A Mission's Leprosy Settlements

In the years before the First World War, the German colonial government in East Africa, as well as in other German colonies, initiated health inquiries and rudimentary treatment programs. The aim was to prevent the spreading of infectious diseases to Europeans in the colonies, to ensure the sufficient availability of a colonized workforce and to demonstrate the ability to govern colonial societies efficiently. Leprosy, however, rarely burdened Europeans, since infection happened only after close and long-term contact in poor and unhygienic living conditions. The colonial system made sure that such circumstances, in all likelihood, did not affect Europeans. Still, leprosy infection endangered the ready availability of the workforce, and German colonizers intended to compete with other colonial powers in every field of the colonial health sector. While leprosy was – unlike sleeping sickness, malaria, or syphilis – not a priority, the scope of the disease was regarded as a serious enough threat to German colonial objectives. German authorities briefly believed that the drug Nastin developed by Georg Deycke could possibly present a cure for leprosy and allowed tests in leprosy institutions in the colonies. They turned out to be disappointing (Eckart 1997, 319–340; on German colonial health policies cf. Bauche 2017; Ehlers 2019; Walther 2015).

Most governmental leprosy institutions in the German colony East Africa operated in the more populated coastal areas or near larger government posts. They also became testing grounds for new therapies (Eckert 1997, 336–340). After 1900, colonial authorities began to monitor the leprosy situation in their territories regularly. They found leprosy endemic in remoter places, where Christian missions were often the only colonial institutions. These missions readily established leprosy settlements as part of their efforts of evangelization. Thus, governments and missions became "public private partners" in yet another field of colonial rule (Eckart 1997, 329–336; Larson 2021, 10–14).

In Southern Tanzania, the Catholic Missionary Benedictines established several leprosy settlements after 1909 near their mission centers at Peramiho, Kwiro,

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Madibira, and Ndanda. Leprosy work, in concert with other medical services, resulted in a long-term engagement of the Catholic Church in the health sector of the region. While Kwiro parish, for instance, still operates a local health center, the Catholic hospitals at Peramiho and Ndanda have become important parts of the area's medical infrastructure (Bruchhausen 2006, 353–357). In 1887, Benedictine monks and nuns entered coastal Tanzania and extended their reach to Southern Tanzania during the 1890s (Napachihi 1998). After the major colonial war of 1905–06, the so-called Maji Maji Rising, education and health policies became door openers for evangelization and state building (Hölzl 2016).

The mission's leprosy work added to the general trend of expanding colonial public health, but it also answered to the local conditions. Medical work had hardly been professional during the German colonial period. Priests and nuns with a few weeks of training as nurses, at best, were dispensing medicine, tending to wounds, and administering the last rites (Bruchhausen 2006, 299–314; for a biographical example, cf. Brockmeyer 2021, 104–112, 163–178; on the prevalence of social care rather than therapy, cf. Eckart 1997, 328). Leprosy became a starting point to establish a more lasting and professional medical infrastructure. From the 1920s, the missions at Ndanda and Peramiho also employed medical doctors, e.g., Sister Dr. Mary Thekla Stinnesbeck. She headed Ndanda Hospital, including the leprosy settlement, from 1927 to 1958, advanced new therapies, built up lab capacities, and made the institution a training site for African health workers (Stinnesbeck 1935; Hertlein 2017; Bruchhausen 2006; Dreier 2015; Iliffe 1998, 42).

The leprosy settlements in Southern Tanzania in the 1920s through the 1940s were quite large villages, housing several hundreds, sometimes more than a thousand patients, who dwelled in and around a treatment center and a church or prayer house.[1] Mobile patients would build their own small homes in the local style and tend to their own fields and gardens. Those who were unable to fend for themselves lived in huts near the center of the village (Anon. 1921, 60–65). Increasingly, during the 1930s and 1940s, the improvised structures gave way to larger residential, therapeutic, and liturgical brick buildings. BELRA, for instance, funded modern treatment buildings for the settlements at Peramiho and Ndanda; both places, in turn, became testing grounds for BELRA's chaulmoogra injections.[2]

1 For the description of the social life in these leprosy settlements I rely on my earlier study on the Morogoro settlement at Peramiho Mission (Songea), Larson's recent article on the Tabora settlement at Kwiro Mission (Mahenge), and Dreier's account on the same institution in the 1930s to 1970s (Larson 2021; Dreier 2015, 185–192, Hölzl 2015).

2 As Dreier reports for the Mahenge leprosy settlement (Tabora village), injection treatment was phased out in the late 1930s. With the end of curative treatment options, medical services as a whole seemed to have suffered and the situation of leprosy care was in steep decline. The mission reinvigorated leprosy work when new drugs became available in the 1950s; cf. Dreier 2015, 190–192.

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Patients were not interned in these institutions, but were able to move independently and did so, sometimes moving back to or visiting their places of origin, sometimes choosing to live further away from the settlement's center. They were largely free to interact with their families if the symptoms allowed it. A large part of the patient population grew their own agricultural produce, ate their own food. They received regular medical treatment, education (with a bias towards religious subjects), and other benefits (garments, special food items, tools, medals, prayer objects). Treatment was voluntary but connected to the livelihood of patients who had settled on mission land. Conversion and adherence to the Catholic Church was expected and most benefits were tied to some form of openness to evangelization, if not medical therapy: for instance, significant gifts were handed out during the Christmas festivities (Weber 1923; Gilg 1932). Missionary sources do report conflicts with patients' families, as well as baptisms without the consent of families or patients themselves (Morrissey 1936). However, coercion seems not to have been the rule. Non-leprous patients and their families resisted involuntary baptisms in the hour of death, for instance, by removing patients who were about to die from the hospital grounds. This left Ndanda hospital with a very low mortality rate, as the resident doctor remarked (Stinnesbeck 1933, 178).

When the mission introduced regular treatment with chaulmoogra oil in the late 1920s, African health workers administered the weekly injections under the supervision of European nurses and doctors (Stinnesbeck 1936). These relied on African agents for practical treatment, heavy labor, language translation and socio-cultural expertise. Gradually, the education and expertise of African personnel changed. In the early decades of mission work, African intermediaries primarily relied on their language and cultural skills. During the 1930's, health workers were becoming professionals who had received several years of specialized training and completed government examinations (Groß 1937, 33–35; Bruchhausen 2006).

Both European and African personnel had to rely on patients' cooperation. As Megan Vaughan put it: "Even the most ardent medical missionaries, who had at times tried to make leprosy sufferers into blank pages, in which to inscribe their ideas about new African identities, had generally found themselves reinventing village life and African 'traditional' structures of control in their leper colonies" (Vaughan 1991, 88). This concerned the immediate treatment by at times painful injections and regular appearances at the treatment center, but also the social order of the quite large settlements, the upkeep of buildings and infrastructure, and the subsistence of most of the inhabitants of the settlements. Force could hardly have achieved this level of cooperation. The German medical officer Richard Wolf had attempted the internment of over 400 leprosy patients in a camp in Southeast Tanzania (Kionga) in 1910, threatening punishment if the inmates did not contribute to their sustenance by providing agricultural labor. The patients resisted, demanded assistance, and walked out of the camp after a few weeks (Eckart 1997, 325).

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Similarly, missionaries needed cooperation in the field of evangelization. They would visit the village regularly for mass, prayer, or baptism. African mission teachers, however, were the backbone of the evangelical work, giving daily instructions, fending off other evangelists, and watching over the continuous observance of the creed (Hölzl 2016). Yet the mission's medical and educational staff did not live in the settlements. Hence patients largely organized social life themselves, under the supervision of a government appointed chief (Sr. Konstantia 1929, 199–200). Missionaries and doctors, however, controlled goods, which gave them power to ensure compliance: some were economic (nutrition, tools, paid jobs), some religious (the Christian rituals and the "goods of salvation," to quote Max Weber), some medical (access to treatment) (Weber 1986, 247–248).

To sum up: the life in the leprosy settlements was structured by a variety of interactions of cultures, material interests, and social groups. Patients had various social roles, as members of families, as participants in local economies, as practitioners of religious creeds and cultural traditions and as subjects of colonial administrative rule. Doctors, nurses and missionaries had to adapt therapies and policies to these interactions and could only do so because they were relying on a number of African intermediaries such as nurses and teachers. The following paragraphs examine how these social realities turned into narratives.

Local Stories and Grand Narratives: Connecting and Scaling

Advocates of colonial anti-leprosy work proposed "to rid the empire of leprosy" (Anonymous 1928, Cover). This was the motto of a prominent medical advocacy group, the British Empire Leprosy Relief Association (BELRA). It constitutes a kind of narration *in nuce* because it plots medical interventions along a grand utopian trajectory. Local and particular narratives link up with such longer, more elaborate narratives about colonial leprosy work.

From a spatial point of view, narrating leprosy was as an exercise in *scaling* and *connecting*. BELRA's journal *Leprosy Notes* (later: *Leprosy Review*) provides ample evidence of this. The mission statement of BELRA, for instance, connected local medical efforts and individual casework with the grand medical trajectory of this organization and its vision of empire:

> The British Empire Leprosy Relief Association … has as its object the *ridding of the Empire of leprosy*. The Committee of the Association believes that if this object is to be achieved it needs the *co-operation of Government in India and the Colonies and Protectorates, the Missionary bodies carrying on work in those territories, the commercial community and the natives of the various countries*. In order to secure such co-operation the Association, which is a voluntary body, has done all that is possible to se-

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> cure the formation of branches of the Association in each part of the Empire where lepers are to be found. Each branch of the Association is responsible for the work in its own area, but the Association seeks to aid in every way possible. (Anonymous 1928a, 2; emphasis added)

This short paragraph establishes at least three important connections: of the metropole and its various peripheries (1), of local colonial agents and the umbrella organization (2), of government, civil organizations and colonized populations (3). Imperial society is portrayed as a tightly woven network of agents of various "classes," respective social groupings which work together in harmony for the greater good. In this greater framework, leprosy and the fight to "eradicate the disease altogether" (Anonymous 1928a, 2) acquired a metaphorical quality. If BELRA had not gotten rid of leprosy yet, it had at least put together a vision of imperial society, in which anything was possible if cooperation at all levels and between all classes was assured.

In 1940, the medical secretary of BELRA and widely acknowledged leprosy expert Ernest Muir published a sweeping survey on *The Leprosy Problem in Africa*. Muir had toured the British colonies in West and East Africa to assess the state of leprosy treatment and facilities on invitation by the British Colonial Office. In his survey, he presented the Uzuakoli Settlement in Nigeria as a specific and localized model institution. The site was run by the Church Missionary Society and received grants by BELRA:

> The Uzuakoli Settlement is thus much more than a well-organized center for segregation and treatment of lepers. It is rather the hub of a wheel which is gradually radiating in the village life of the people. It is a center of training of leprosy patients, who are found to be the most enthusiastic and efficient apostles of anti-leprosy methods. Its sanitary village planning is gradually "taking on" with the people. What astonishes one most is the modest cost at which all this is managed, though doubtless with more resources it could be more rapidly extended and more effectively done. To return to the two different points of view regarding the control of leprosy referred to above, we find in the Uzuakoli and similar institutions that instead of waiting till sanitation and other general improvements bring about the disappearance of leprosy, the disease itself is used as a key with which to open the door to general educational, sanitary and agricultural reform, this being done with the aid of voluntary societies at a minimum of expense to Government. In any case it may be said that the solution of the leprosy problem will be closely bound up with the future progress of Africa. (Muir 1940, 142)

The leprosy settlement becomes quite effectively a metaphor for empire: A "centre … gradually radiating" to its peripheries, "well-organized", "sanitary" with "most enthusiastic" subjects who become the best advocates of good governance, and all this

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at a surprisingly "modest cost." To "rid" an "empire" of a widespread infectious disease equals making whole the empire itself.

Denominational missions would not subscribe to this secular and political narrative in the same way or degree. As Megan Vaughan wrote about English protestant missions: "Each sick person was a potential convert, each had a 'soul' as well as a body to be attended to … Healing, for medical missionaries was part of a programme of social and moral engineering through which 'Africa' could be saved." In this respect, "the mission hospital" was a place where the "individual patient was 'created'" (Vaughan 1991, 74). There are some structural similarities with regard to narrative *scaling* and *connecting*: much as in BELRA's narrative, leprosy work for missions was a means to an end. This end was imperial in a transcendental sense: it was supposed to do two things – (1) to open up a site for practicing faith and sacrifice to Christians in Europe (as donors) as well as in the mission field (as medical and care workers), and (2) to function as a door-opener for the evangelization. Leprosy work, again, connected the European metropole with the colonial mission fields, the Church's old constituencies with new ones and worldly efforts with divine redemption. It connected the local, daily struggle for converts with the global Church and God's empire.

A concise rendering of the local, global, and transcendental framing of leprosy work can be found, for instance, in a travel account by Norbert Weber published under the title *Children of Sorrow* around 1923 (Weber 1923, cf. Larson 2021). The Benedictine Arch Abbot was based in Germany but had travelled the mission fields in Africa and Asia. Weber described a "walk" through three of the leprosy settlements operated by the Benedictines in East Africa (at Peramiho, Madibira, and Kwiro). Several chapters are devoted to portraying social life in the settlements, judging the moral character of the patients (their contentment and gratitude), as well as praising the nurses' sacrifice. Frequently, Weber's account also featured direct interactions and conversations with patients. Further chapters narrate critical moments in the religious life of the village, the celebration of Christmas (when grateful patients receive gracious gifts sponsored by European Christians) as well as a baptism ceremony. The finale of the pamphlet recounts, in the style of a sermon, Jesus Christ's encounter with the ten lepers (whom he healed and of whom only one returned to express his gratitude). Weber reminded his European readers of Europe's own history of leprosy and ended with an appeal to repay God's grace by donating to African lepers: "We so favoured by His love and benefits could find no better form of expressing our gratitude than by sharing with others less fortunate the benefits we have received in such an abundance." Weber pointed out that donations and assistance to missionary endeavors were not merely altruistic gestures: the transaction of goods only seemingly went directly from the European donors to the African lepers, but "the work of saving the souls of others is in reality the surest guaranty for our own predestination" (Weber 1923, 49).

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Melania Vollmer, a leading figure of the Missionary Benedictines Sisters, published a short travel account in 1925. Travelling across Southern Tanzania, Vollmer perceived a huge demand for medical care. In particular, she noted the competition of Anglican missionaries, who had been offering professional medical treatment at several stations in the area since the turn of the 20th century (Bruchhausen 2006, 296–298). To retain the Catholic influence, Vollmer urged more emphasis on the material welfare of the people: "mission doctors – men and women – willing to give sacrifice" were in urgent demand. "From the very beginning the expansion of Christianity rested on acts of compassion" (Vollmer 1925, 121). The true aim of missionary medical work was not merely pioneering medical discoveries or curing the sick, but to provide the foundation for evangelization. The competitive tone was characteristic and added to the imperialist character of the mission's leprosy narrative.

A third aspect of the leprosy work and other medical efforts of missions emerges in a travel account by Thomas Ohm. Ohm was a professor of religious studies and member of the Missionary Benedictine congregation. He visited East Africa in the 1930s. The account I am referring to here focuses, however, on a journey to South Africa. Ohm underlined that missionary medicine was primarily a service to God and a door opener for mission work. Yet, more importantly the mission's new capacities of professional Western medicine could effectively "destroy the basis and the core of heathendom as well as its strongholds," because Western medicine was "destroying traditional, heathen concepts of disease and … healing." Consequently, it undermined traditional society ("heathendom"). Ohm stated that it was possible to "annihilate the bulwark" and "stronghold" of traditional societies, the "witch doctors" (Ohm 1934, 14–17). In this martial narrative as in other medical missionary writings (Vaughan 1991, ch. 3; Hölzl 2011; Bruchhausen 2006, 317), local ritual and healing experts transformed into the prime antagonists in the fundamental and existential struggle of expanding God's empire.

These three missionary travel accounts highlight how worldly and religious characteristics intersected in missionary narratives of colonial public health: the service primarily rendered to God and the instrumental character of health initiatives in relation to evangelism, often not only directed towards conversion, but in a belligerent tone against European and African competitors in the field.

"Superstition" was also a frequent trope in the narratives on leprosy work in Africa disseminated by BELRA, not least because missionaries published in the association's journal and propagated the infamous figure of the "witch doctor" (Murray 1931; Wallace 1932; Robertson 1932; Langauer 1940). BELRA's leprosy experts identified similar obstacles from a medical perspective. For instance, Ernest Muir:

> How does the native African regard leprosy? He has, of course, *superstitious ideas* connected with the breaking of taboos. … Leprosy is supposed to be the result of

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> vengeance of the gods for something done to provoke them, either by the victim himself or by his ancestors. (Muir 1940, 137; emphasis added)

The figure of the ignorant and superstitious "native African" was hardly a strong antagonist to the cause of eradicating leprosy. The colonized were sketched as immature, yet intelligent and ready to develop sounder and healthier ideas on leprosy and diseases more broadly:

> There is a very definite responsibility on the shoulders of the British public, which they cannot shift on to the back of Government. We who claim to be a democratic nation have deliberately taken over or adopted a number of countries peopled by backward races. Anyone who adopts a child holds himself responsible for its education and well-being, and above all for its health. We are proud of these colonies and few would be willing to give them up. Surely then it is our duty to see that everything possible is done to free them from the living death of leprosy and the ignorance, superstition and insanitary conditions which breed leprosy. (Anonymous 1938, 53)

Muir concluded: "In controlling leprosy it is therefore necessary to study the ideas of the natives, and after sympathetically separating out useful knowledge and customs from harmful and useless superstition, to help them to put their correct ideas into practice" (Muir 1940, 138–139).

Creating Leprosy Plots: Conversion and Self-Transformation

Texts about leprosy in the colonial public health context frequently employed *conversion* to structure narrative plots. The comparative perspective on religious and secular contexts highlights several characteristics: for one, conversion was hardly an exclusively religious concept, but was also present in secular texts – as a "conversion to modernity," modernity understood here as a colonial category (van der Veer 1995; Cooper 2004). Secondly, conversion of "others" involved transformation of one's own self; much like missionaries only completely fulfilled their role when they achieved conversion, medical experts truly became worthy imperial agents when they achieved cure of bodies and minds of patients. Thirdly, these conversions of the colonized and self-transformations of the colonizing individuals metaphorically linked up with the secular and religious empires as grander collective subjects.

In the Benedictine mission care work for lepers was relegated to nuns and male African medical workers for theological reasons. Male priests were – in theory – to concentrate exclusively on the primary aim of evangelism. Close encounters with the physical body supposedly presented a worldly distraction. As Lorne Larson un-

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derlines for the period before 1914, leprosy work provided Benedictine nuns with an attractive field of agency beyond the ancillary position of organizing the kitchens, washhouses and farmsteads of the larger mission stations. This significant transformation and expansion of professional activities of female Catholic missionaries continued in the 1920 to 1940s. Although baptisms were the prerogative of male priests, nuns exercised this key rite frequently on patients, claiming emergencies. Already in 1910, the mission's leader, Bishop Thomas Spreiter, warned missionaries and explicitly lay brothers and sisters of turning the mission's health institutions into "factories for baptisms."[3]

In the narratives presented to their home audiences in Germany, nuns developed this transformation of their role and pushed gender boundaries. They transgressed the narrow paths laid out for women in mission theology and canon law: they reported not only conversions of patients, but also repeatedly the baptisms that they had themselves performed. A nun's first baptism resembled a rite of initiation not only for the baptized but for herself. A great number of baptisms were considered as a stroke of luck. The mission journal of the Missionary Benedictine nuns, for instance, featured following characterization of Sister Cosma in 1936: bringing the "poor lepers to god … and even baptizing them herself' was her "special joy." She had been "lucky very often", the journal stated: nine people had died at the leper settlement at Peramiho that year, "eight of which were baptized in their hour of death" (Anonymous 1936, 11–12).

The same journal published a travel account – another "walk" to a "leper settlement" – by Sister Bilhild Groß who was a newcomer at Peramiho mission station. The other sisters had done her the favor of sending her to the leprosy settlement to tend to a mother with a newborn and several other children. The woman was infected with leprosy and apparently very sick. Sister Bilhild Groß rejoiced. According to her account, overpowering religious emotions accompanied her journey:

> [The women] sat at the fire with her youngest child, a three-month-old boy. How her eyes shone in her completely disfigured and consumed face, when I told her, that I came to baptize her. After the necessary questioning I exercised the great, eternal act that opens the gates of heaven. I gave the baptized the name Theresia, Josepha, Emma. *I felt very peculiar, almost not of this world.* We prayed together, the new Christian received a little picture and a medal. Eight days after, the women died. *I was really lucky. Some sisters are here for years without having the chance to baptize.* O dear black Theresia, Josepha, Emma pray for me at God's throne. May he give his blessing to my mission work among your fellow countrymen and women! (Groß, 1930, 224; emphasis added)

3 Circular Letter, Bishop Spreiter, 15 Jan 1910, Archive St. Ottilien, Z. 1. 01.

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The nun put forward a powerful narrative about Catholic women's claim to colonial agency. The baptized Theresia – her original name now erased by ritual and narrative – is presented as a willing object to the sister's powerful acts. The name Theresia is no coincidence here. It likely refers to Saint Thérèse of Lisieux, a nun who died in young years of tuberculosis 1897. Her autobiography *The Story of a Soul* was published shortly after her death and became a bestseller all over Catholic Europe. Thérèse of Lisieux (known in English as "little flower of Jesus") constituted a role model for Catholic nuns in the early 20th century, especially after she was elevated to sainthood in 1923. Thérèse expressed the wish to become a missionary and a soldier to expand God's empire. She lamented that as a woman she could not and had to resort to the so-called little ways of faith (Thérèse 1996).

Once women missionaries acquired medical degrees, they were able to expand their roles further, wielding expert authority in the missions' increasingly important health sector. Often this involved setting themselves off against indigenous women by combining religious and secular tropes of Christian and Western superiority. Anna Dengel (1892–1980), who practiced as a mission doctor in Rawalpindi (Punjab), published an appeal to female German doctors and medical students to join the missionary cause in 1925. Dengel was one of the first female German Catholic mission doctors. In her account, she characterized Hindu women as good mothers, who wished to acquire the best health care for their children. At the same time, Dengel portrays them as ignorant, filthy, superstitious, and "like children." Muslim women appear as members of a wealthy upper class, rich but confined to their home without "nurture for body and brain" (Dengel 1925, 20). European missionary women, much to the contrary, are presented as faithful, hard-working, physically agile, and fearless professionals:

> In a country were climate, lack of hygiene, epidemics, ignorance, superstition, flies and filth all come together, there is a lot misery to ease. Where two million children under the age of two die annually, there is ample opportunity to baptize. … A new beautiful, blessed, but hard profession is now open to girls: To set out to hot or cold uncivilized or barely civilized, dangerous or less dangerous countries as mission doctors, nurses, or apothecaries, in order to contribute to the propagation of faith and do good according to talent and grace. (Dengel 1925, 20)

Religious motivations are in the foreground of Dengel's narrative. Yet, the undercurrent of a medical civilizing mission, which enabled European Catholic women to transcend conventional gender roles, is clearly distinguishable.

The prominent role of female medical doctors in missions is somewhat exceptional in the colonial health care sector. The medical experts of BELRA were men and they conceptualized colonial medicine primarily as a white, masculine sphere. When the organization's medical adviser, Ernest Muir, arrived at the Benedictine

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leprosy settlement at Peramiho in 1938, he perceived a site that "has grown to proportions which are far beyond the control of the present staff." He wrote: "I consider that the Sister-in-Charge and the African Superintendent are both exceptionally devoted and able workers. … but to conduct this Settlement with full efficiency there should be *a fulltime medical man*" (Muir 1939, 67–8, emphasis added). This imperial masculinity was not only acquired by racial identification, birth or education. It demanded full engagement for the medical civilizing mission. Ridding the empire of leprosy meant saving the empire from dysfunctionality. Curing leprosy and having the colonized population voluntarily subscribe to treatment signified not only the colonized populations' acceptance of colonial rule but their willingness cooperation. This made the empire whole, analogous to the human organism.

The positioning of the "medical man" in relation to other roles (European women, African health workers, patients) in the *mise-en-scène* of colonial leprosy becomes apparent in another one of Muir's accounts. As mentioned, the Uzuakoli settlement (Nigeria) served Muir as a kind of model institution, or lab in Helen Tilley's metaphorical use (Tilley 2011), for a well-functioning empire:

> The *doctor in charge* is a Methodist missionary; a second doctor is being sent out by the Leprosy Association, and the Association also supplies two layworkers. The doctor's wife and another honorary lady assistant help with the women and children, and there are four nonleper African workers. The rest of the work is done by the patients themselves. There are eleven hundred patients housed in neat rows of sanitary huts, arranged in villages within the settlement. The site is healthy and suitable for agriculture. *From the doctor's bungalow one gets a fine view over miles of undulating woodland country.* The hospital, treatment centre and other administrative buildings and the European staff quarters are of a permanent type, and have been erected chiefly with the labour of patients. The treatment arrangements are excellent, including occupation therapy in all its forms and communal physical exercises. (Muir 1940, 140; emphasis added)

The "doctor in charge" is not only in the center of the narrative's *dramatis personae*, but also put in an extraordinary geographical position. The elevated location of the doctor's residence, which allows for a mile-wide view of the country below, reminds of Marie Louise Pratt's ingenious observation of the "promontory scene" in colonial travel narratives. Such a viewpoint renders the observer the "monarch of all I survey" (Pratt 1995, 197, 217). Of course, the quote also steers us to Foucault's prison wardens and their panoptical gaze (Foucault 1977). Although the perspective of choice of the leprosy expert should perhaps be a microscopic one, Muir emphasizes the big picture, the macroscopic view on the colonial landscape. The protagonist is more like a general on a battle hill than a scientist behind a desk, examining samples under a microscope.

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In this narrative, patients are cured physically and become socially productive members of the institution, while the medical expert is transformed into a civilizing missionary and key agent of empire. On the structural level, this is remarkably similar to the conversion narrative of missionaries that render patients faithful members of the Christian community, while transforming themselves into true agents of God's empire.

Narration and Materialities

Asking how leprosy narratives were assembled and what they did, a further actor (or agent) comes into play: the disease in its material aspects and the ways by which it communicates or reacts to treatment, its symptoms and trajectories (on why materiality matters: Latour 1999 and 2004). If communication is perceived as comparatively slow and affecting a specific portion of society, as was the case with leprosy in the colonial context of the 1920s and 1930s, a disease may more readily be categorized as a disease of *others* (Muir 1938, 12–14).[4] This, in turn, enables close inspection and care. The disease becomes connected to a different set of emotions, i.e., compassion rather than fear. Paradoxically, the very "otherness" of leprosy, as a disease of the colonized poor, explains the illusion of intimacy and tilted emotional relation that the above-cited missionary narratives transported to European publics. In this respect, leprosy resembled, for instance, hookworm disease or yaws. However, these were less relatable to the biblical and European historical traditions. Leprosy differed from highly infectious diseases which were communicated over a greater distance (e.g., via insect vectors) and thus were not confined to a particular social stratum. The "colonial other" infected with malaria or sleeping sickness was conceived of and narrated less as a patient to be cured or even commiserated, but as a dangerous carrier of a disease, a threat to be controlled, separated, and confined.[5]

How material ways of communication have affected narratives becomes obvious when looking at sexually transmitted diseases such as syphilis. During the long 19th century patients were often branded as immoral, as adulterers or prostitutes. The disease served as a signifier of sin. Around the time of the First World War, secular doctors and public health administrations in Europe tried to change this

4 Conversely, African societies were accused of cruelty and superstition, because they feared and ostracized members infected with leprosy (cf. Dow 1945, 57–63).

5 See the variety of contributions in Bashford and Hooker 2014. It was, of course, possible that general considerations of racial segregation and "purity" in a settler society led to very different interpretations, e.g., in 19th century Australia. The Australian government introduced racialized policies of "isolation, separation, and containment" against leprosy patients, much in line with general health policies (Bashford/Nugent 2014).

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narrative. Moralizing the disease seemed to block efficient prevention and treatment, as the infected tended to hide the disease out of shame and fear of stigmatization (Sauerteig 2001; Morick 2026). Christian activists, however, often adhered to the older narrative much longer (Ratschiller 2023; Hölzl 2024). Leprosy, in comparison, was recounted as a disease of social outsiders, but generally did not come with the same degree of moral deviation and subsequent ostracization. Megan Vaughan, however, points to cases of patients suffering from both diseases, and moral connections that were drawn between them (Vaughan 1991, 82).

The relations of material contexts and narratives are also historically volatile: if, for instance, curative treatment is believed to become available, the narrative of a disease changes. Curability alters roles, hierarchies of characters and plots. Stories of compassion, of self-sacrificing care, or of moral outrage may then turn into martial narratives of heroic conquest and eradication campaigns. The figure of the self-sacrificing female care worker gives way to the pioneering male medical expert. For instance, Victor G. Heiser, one-time director of a leprosy isolation colony on the Philippines (Culion Colony on Cebu), as well as health director of the US colonial administration of the country, and then a director of the International Board of Health (Rockefeller Foundation):

> The real gains have been due […] to the disinterested cooperation of physicians and sanitarians who have shared knowledge and experience, and helped governments and institutions to organize systematic measures of isolation and treatment. Their aim has been not merely to relieve the afflicted but to protect whole populations. These *modern crusaders* will not be content until leprosy has been banished from the world. (Heiser 1925, 688; emphasis added)

Changing the narrative on leprosy, however, was a gradual, non-linear, and not necessarily teleological process. The leprosy campaign of the 1920s and 1930s and its narratives are exemplary of this volatility. The perceived efficacy of the chaulmoogra oil injections initiated and motivated campaigning for leprosy eradication. The disease featured as a simple and conquerable entity in this campaign. Although the pathogen (*Mycobacterium leprae*) was known at the time und used for diagnosis, it hardly appeared in the narratives. Leprosy's long history served to highlight the spectacular novelty of 20th century pharmaceutical cures. While the use of substances derived from the chaulmoogra plant was old and historically located in Indian medicine, medical experts (such as Heiser, Rogers or Muir) from various countries introduced new methods of extraction and marketability (as powder, concreted liquid) as well as various injection techniques. They attempted to improve the viscosity as well as tolerability of the medication and to reduce the cost of production and shipment (Rogers 1934).

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In answer to this, Leonard Rogers, a prominent physician and colonial medical expert, explicitly called for a paradigmatic shift regarding leprosy – from caring to curing:

> The organisation of the great humanitarian work of *caring* for the leper, which is so largely in the hands of Christian missions of various denominations, requires to be remodelled in the light of the new situation, for it is evident that a far greater service is rendered by *curing* the leper in the early stages of the disease, than in providing a home for him after the affection has reduced him to a helpless wreck. (Rogers, as cited in: Anonymous 1928a, 3)

Rogers and BELRA counted on chaulmoogra oil, which, they claimed, to have developed into a medication that was efficient, cost-effective, and tolerable for patients. The organization not only distributed the medication and offered advice on treatment. It also distributed the seeds of the Indian chaulmoogra tree to be planted near leprosy hotspots (Rodgers 1928, 6–9).

Yet, by the early 1930s doubt was mounting about the success of the chaulmoogra treatment and the curability of leprosy. With increasing diffusion of the therapy and the substance, more and more negative reports circulated among leprosy experts: They exposed low curing rates and many relapses after treatment had ended, as well as adverse physical reactions to treatment. In 1935, the *Leprosy Review* decided to publish an article by José Rodriguez, a very experienced doctor who headed a children's clinic on the Philippines and whose studies casted further doubt on the "curability" of leprosy. They suggested that not even in early cases and in children was the chaulmoogra treatment very effective. Rodriguez noted that after nine years of treatment, "we are no longer so sure that the chaulmoogra treatment is effective in this very early stage" (Rodriguez 1934, 102).

This met with an emotional response from the BELRA medical community. The journal editors did not deny the findings, but expressed confusion, sadness, even grief, and they signaled hope. Rodriguez positions were "startling" and cause for experts to think "furiously." The editors conceded that the initial expectations for the treatment were very much "diminished." Even though chaulmoogra was the only available drug, it was effective only in a very small group of patients. The editorial ended with a plea that is striking due to the density of emotive and psychopathological references:

> Let us continue the search for better remedies but let us not forget that our most efficient remedies still are the derivatives of hydnocarpus oil, and that these cannot be *put into the limbo* of forgotten things. We would strike this note of *hopefulness* that while our ideas concerning specific treatment *are apparently in the melting pot*, we have never been more *convinced* of the value of leprosy work and the pos-

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> sibility of the control of this scourge than we are to-day. We must *keep our vision clear*, not letting our *enthusiasm* for treatment *blur our view* of prevention, or be so *obsessed* by apparently unfavourable reports that we *lose our faith* in the efficacy of all treatment. We plead for a *sane* outlook so that our view of the problem may be complete, and no part of the picture be out of focus because one aspect of the problem is stressed at the expense of another. (Anonymous 1934, 100–101; emphasis added)

This statement is indicative, because it appeals to readers not only as an expert group, but as an *emotional community* bound by the heroic narrative of colonial leprosy eradication (Rosenwein 2010). Critically, this heroic narrative hinged on the curative efficacy of the medical treatment.

In the process, the disease itself acquired a different quality in the eyes of the BELRA experts. Its medical secretary, Robert Cochrane, stated: "One must confess that we have a long way to go in our search for better remedies for the disease. It may be that leprosy does not lend itself to specific treatment and that our greatest advance will be along epidemiological and preventive lines" (Cochrane 1934, 139). In short: back to square one. The *Leprosy Review* editorial speculated about physical dispositions to contract leprosy or not, and whether "the life of the Mycobacterium leprae" ought to be conceived of more like a parasite: "We have felt for some time that the M. leprae in many of its aspects can be looked upon as a cellular parasite, and if this is the case then, as with other parasitic diseases, a symbiosis tends to be set up between the parasite and its host. It is well known that specific therapeutic remedies, in the case of parasitic diseases, are apt to fail" (Anon. 1934, 100).

Unexpectedly resisting treatment, the pathogen acquired a much more central place in the narrative of leprosy. Having previously almost disappeared under the general entity of leprosy, it now became a very particular agent whose character and life story warranted much closer attention. Scientists thus stepped up efforts to isolate the Mycobacterium leprae and reproduce it in vitro under lab conditions (Muir 1938, 105–109).

Missionary health policies never fully embraced the curative narrative and retained a broad focus on care, compassion and evangelism. Missionary doctors navigated between various strands of narrating leprosy, alternately stressing the curative and caritative aspects of their work. A case in point is the Thekla Stinnesbeck, a Benedictine nun with a medical degree who headed a mission hospital. A whole set of articles on her work are available to study – published in *Leprosy Review*, the German medical missionary journal *Katholische Missionsärztliche Fürsorge* and in illustrated mission journals, including the Benedictine women's journal *Missionsecho*. Stinnesbeck's reports for *Leprosy Review* were more matter-of-fact with less emotional emphasis on the curative aspects of leprosy work than most texts of the journal: they reduced leprosy work to statistical results of treatment and infection in

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the area, accounts of building and therapeutic activities, and to ethnographic descriptions of traditional approaches to leprosy among the societies of the region. Stinnesbeck's portrayal of indigenous attitudes on leprosy are to degree more expressive and indirectly stress an alleged superiority of European biomedicine. Local African societies and patients are described as "cruel," "afraid," and lacking "confidence in European treatment." According to Stinnesbeck, indigenous societies in the area regarded leprosy as "infectious and incurable disease," reacted with separation of varying degrees of severity, and were unable to detect early cases. Yet, they had herbal medicine that could stall the development of disease for some time (Stinnesbeck 1936, 1936a).

In comparison, Stinnesbeck's articles for mission journals were quite different. These also contained statistics of treatments and expenses, accounts of medical procedures and descriptions of the built environment of the settlement. Yet this information was framed by an emotionally dense appeal to the readership. It presented leprosy patients as worthy and in need of assistance as well as compassion. Between 1933 and 1936 Stinnesbeck published the very same text in three different mission journals. The publications – all involving the "walk to the lepers" – differed in their aspects: the *Leprosy Review* had featured several photographs, one of Stinnesbeck performing an operation on a gangrenous foot, one of an African nurse (possibly Vincent, the mission's leprosy worker) dressing a wound (Stinnesbeck 1936). The article in *Katholische Missionsärztliche Fürsorge* came without any illustrations (Stinnesbeck 1934). The journal of the Benedictine Fathers of St. Ottilien (*Missionsblätter*) featured an orderly photograph showing Dr. Stinnesbeck teaching four rows of male African student nurses in a small lecture theater (Stinnesbeck 1933). The journal of the Benedictine Sisters (*Missionsecho*) had two photographs depicting Stinnesbeck in a caring role: one surrounded by an Indian patient's family on the doorsteps of Ndanda hospital and the other among joyfully dancing female leprosy patients at the settlement (Stinnesbeck 1934a). The curative aspects of leprosy work had become part of the missionary narratives. Yet they were never as central to the narrative as they were in a more secular colonial health context, where the practical failure to cure had significant impact on narration.

Framing Patients' Agency

Leprosy patients not only navigated the conditions of colonial health policies but also shaped them to a considerable extent. As laid out above, leprosy settlements in Southern Tanganyika between the World Wars were large, open, and underfunded institutions. Many of the patients led rather self-sufficient lives, but received some assistance, care, medical treatment and evangelical education from teachers, nuns, health workers, and doctors. While these had some powerful assets to bring to ta-

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ble, the whole idea of evangelical leprosy work relied on the cooperation of patients, who in the end had to attend regular treatment and education for years. Of course, agency depended on the severity of the symptoms a patient experienced. Abandoning the settlements was less of an option for patients with more severe symptoms that ostracized them from communities and immobilized them.

Coercive models of leprosy work were difficult to uphold. Largely failing German attempts at internment in Southern Tanzania during 1910s are mentioned above. The American colonial health administration on the Philippines (Anderson 2006) centralized internment at Culion leper colony (est. 1906 on Cebu) under the administration of the US occupational government and health experts of the Rockefeller Foundation. BELRA perceived it to be a failure brought on by the resistance of the involuntarily interned patients and the refusal of the population to hand over the infected to the government for distant internment. BELRA took the inability of the full force of the US colonial military administration and medical expertise to force treatment on people as a hint and put forward alternative approaches, which were also considerably less costly (Muir 1938; Rogers 1929; Anonymous 1928a). Suggesting outpatient clinics and open leprosy settlements, where patients could organize their economic and social life themselves, BELRA was actually selling the status quo in the mission institutions as an innovative anti-leprosy strategy. Ingeniously, even the subsistence farming of the infected inhabitants of the leprosy villages was remodeled as "occupation therapy" of special "therapeutic and economic value" (Rogers 1929a; cf. Wilson 1930 and Kerr 1938).

As mentioned above, injecting patients with plant-based substances every week for years in open facilities depended on high levels of cooperation. Patients' reaction to treatment forced pharmaceutical researchers to look beyond the therapeutic impact of drugs on the disease and cost-effectiveness. Side effects (the "leprosy reaction") had to be minimized and the level of pain caused by injections reduced (Rogers 1934). This also spurred the professionalization of African health workers, who were responsible for administering the hardly trivial procedure.

The realization that drug therapy promised only moderate success in the immediate future plus the fact that patients in many colonial contexts would not be forcibly concentrated and isolated also pushed preventive concepts such as decentralized "propaganda work" directed at the colonial villages, households and families (Lowe 1934, 40–44). BELRA advocated an integrated approach here under the headline of "Propaganda Treatment Survey Centres." In villages, and in cooperation with local authorities, surveys, information events, and treatment in small clinics (dispensaries) were to go hand in hand:

> First of all, the information available from the decennial census returns is collected. This information, though not accurate, as it has been collected by enumerators who have no special knowledge of leprosy, is useful as a starting-off

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> ground. Villages are visited, and with the aid of the Union Presidents and Village Watchmen known cases of leprosy are looked up and members of their families are examined for early signs of leprosy. By conversation, demonstration of charts and lantern lectures, the villagers are taught about leprosy--how it is contracted, how it may be prevented and how remedied. An out-patient clinic is opened at the headquarters of the thana [local administrative unit] and patients are treated there once or twice a week, while on the remaining days of the week other villages are visited. Alongside of treatment and propaganda the survey proceeds. With the help of grateful and willing patients more and more cases of leprosy are found.… In this way much useful information is collected which again is used in propaganda work. The sufferers from leprosy are generally found to be' eager for treatment. Within three or four weeks of starting such a centre as many as two or three hundred patients have been found to attend for treatment. Villagers are taught to isolate infectious cases in huts outside the village, and to discern the earliest signs of disease and bring their patients in the first stage in which leprosy is so remediable. (Muir 1928, 5)

This text is quoted here at some length because it demonstrates how experts folded patients' considerable agency back into the powerful narrative of colonial public health: by employing refined social engineering and propaganda techniques patients would be happily convinced of the superiority of the colonial biomedical approach to disease.

Extensive propaganda work in tune with local socio-cultural settings was the key to missionary success. For evangelization, just as for medical treatment, missionaries needed a high level of cooperation among the local population since missions expected adherence to Church law and a restrictive set of moral prerequisites. For their evangelical work the Benedictines in East Africa relied heavily on the cultural expertise of African mission workers (catechists, teachers, nurses). These translated and negotiated Christian faith in a wider cultural sense for the various societies in the region. This included education and health policies, which were increasingly bundled up with evangelism during the 20th century. Even if missionaries emphasized the instrumental character of schools and hospitals to European audiences, education and health care were closely tied to religion and vice versa in the mission field, not least because the services were in high demand among potential converts.

Mission teachers were often presented to European audiences as key to local evangelism; sometimes medical workers featured in such a role as well. In the grander scheme of things, however, these key agents were objectified as examples of missionary success. In addition, the colonial social hierarchy was steep: "[t]rustworthy" African mission activists lead local African parishes but deferred to European superiors. In contrast, the Benedictine mission's leprosy patients appeared as malleable, good-natured, happy, but unfortunate stock characters. In the highly individualized conversion stories of female Catholic missionaries,

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leprosy patients appeared as largely empty canvasses to be inscribed with powerful projections of female European imperial agency.

The variable ways in which patients made homes in leprosy settlements and negotiated the offers of missions were reconfigured in missionary narratives as proof of worthiness and convertibility. Missions appealed to European Christians as intermediate, yet powerful agents of God's empire. This becomes tangible in Norbert Weber's 1923 account of his travels to the leprosy settlements in Southern Tanzania:

> These poor afflicted people in their anxiety and eagerness even went so far as to declare themselves willing to cultivate sufficient land to meet the requirements of the entire leper community comprising a large number whose infirmities had disabled them from all manual labour. [We] promised to supply two dozen of the required implements [hoes]… The distribution had taken place amidst hushed silence, but now it was over, a great demonstration of joy followed, manifesting itself in a mighty shout of "asanti" "thank you." … The "stupid" negroes are so often denied both heart and feeling and accused to be strangers to all sensations of gratitude, that after witnessing so striking an exhibition of all these qualities I feel bound to stand the advocate of this much maligned and misunderstood people. (Weber 1923, 15–16, 21)

The abbot's narrative exposes communication strategies of missions for the home constituencies. Weber portrayed Africans as poor, sick and in urgent need of help, at the same time eager, grateful and able to express joy and happiness, if given assistance. European Christian readers were expected to be compassionate and giving in emotional communion with the newly converted – a common trope among missionaries of various denominations (Haggis/Allen 2008). Weber evoked the desired *emotional regime* (Reddy 2001) with authority: "The retrospect on the sufferings of our fellow men *pierces one's inmost soul*, and through the keen *sympathy* with which our *hearts are filled* at the sight of *anguish*, there comes forth a soothing song of *peace and love*, which to the poor sufferer is almost akin to the voice of angels" (Weber 1923, 3, emphasis added). Both, secular and missionary narratives were able to reconfigure and almost extinguish the vital agency of Africans, not by actually removing them from the story, but by objectifying them as part of the syndrome of leprosy, as obstacles to be overcome by social engineering efforts, or as worthy objects of European Christians emotional (and material) engagement.

Conclusion

There were significant differences between religious and secular narratives of leprosy in the colonial context of the 1920s through the 1940s, for instance, in the way

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religious narratives tended to foreground *care* or the triangular and transcendental connection of European Christians, African patients, and God's grace. Medical experts put the work for the secular empire center stage, an empire to be saved and ridded of disease. The *curative* aspect was a prime mover for these secular narratives of leprosy and for the emotional bonds that formed the community of leprosy experts in the 1920s and 1930s.

However, both strands of colonial leprosy narratives had similar structural features: the *scaling* and *connecting* effects that bound together local stories and grand narratives of secular and religious empires; the way conversion and self-transformation stories allowed for narrative plots; the impact of patients on programs and policies; and the disease's structuring effect on leprosy narratives. Religious and secular reports presented distinctly different, yet not fundamentally diverging versions of colonial public health. The colonial mode of narrating pandemics came in different guises but remained with a colonial framework.

The leprosy narratives examined in this chapter have proven to be volatile and multifaceted, so much so that they do not submit themselves to summaries, such as a "story of hope" (Vaughan 1991, 84) or "confidence trick" (Iliffe 1987, 225) played on African patients by European doctors and missionaries. On the contrary, these narratives were impressionable with regard to the physical aspects of the disease as well as the terms and conditions under which African leprosy patients chose to undergo caring or curing treatments. These patients used institutions to carve out space for survival under very dire conditions. However, the impact became manifest on an intermediate and practical level. The grander framework of colonial public health narration remained surprisingly intact.

Perhaps, there was a "confidence trick" to the narration of leprosy after all. If that was at all the case, it worked on the medical and religious experts and their European audiences. Leprosy narratives, secular and religious, had a way of thoroughly masking the profound impact of the material disease and patients' agency alike. Presenting these agents as passive obstacles to be overcome by European ingenuity (in the case of medical experts), or self-sacrificing care and the Lord's grace (in the case of missionaries) allowed the overarching paradigm of the European civilizing mission, and superiority, to largely stay intact. A case of self-deception, as the decades of decolonization were going to prove.

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