

Christian Churches and Leprosy Control in Anglophone Cameroon: The Case of the Manyemen Leprosarium, 1954-1992

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Abstract: This paper examines the role of Christian churches in the campaign against leprosy in Anglophone Cameroon. The study uses the Manyemen Leprosarium as a case study, showing that apart from churches' involvement in the prevention of the disease, they encouraged early case detection, case holding in settlements and consequently, the curing and rehabilitation of many lepers. It argues that the Basel Mission and the Presbyterian Church in Cameroon helped not only in significantly reducing leprosy prevalence in Anglophone Cameroon, but rehabilitated sufferers who were disabled by the disease.

Keywords: leprosy, Anglophone Cameroon, Basel Mission, Presbyterian Church in Cameroon, Manyemen, leprosy prevention, leprosy treatment, rehabilitation.

INTRODUCTION

Leprosy is among the world's oldest and most dreaded diseases [1]. It is a chronic infectious disease, which occurs worldwide [2] The Mycobacterium which causes the disease affects the skin, the peripheral nervous system, the upper respiratory system, the eyes, and liver [3]. The disease, throughout its existence, has been synonymous with stigma resulting not only from socio-cultural beliefs, but also from the dreadful deformities it produced and misconceptions about it until recently [4]. When Hansen discovered the Mycobacterium Leprae that causes leprosy, efforts were made in societies across the world to roll back the disease using prevention, treatment and lepers' rehabilitation strategies that evolved with time and circumstances. As a matter of fact, there were rewarding combined initiatives by governments, medical experts, World Health Organisation, Non-Governmental Organisations, and a plethora of religious bodies to surmount the disease.

In Africa in general and in Cameroon as a whole, in spite impediments embedded in the socio-economic beliefs of the people, colonial and post-colonial governments in collaboration with religious bodies launched an incessant war against leprosy. Although the leprosy elimination campaign started by the Germans in Cameroon was abruptly terminated during World War One when they were shouldered out of the territory, the British and the French partitioned German Cameroon and engaged in leprosy work in their spheres of influence. In what eventually became known in the British section as Southern Cameroons, the

principles of the Mandate and Trusteeship Agreements provided the potential for combined efforts against leprosy between the colonial government and missionary societies. This was partly the context in which missionary bodies such as the Cameroon Baptist Convention and the Basel Mission came on board the leprosy elimination campaign in the territory. The leprosy work of these missionary bodies was subsidized by the British Government through her Colonial Development and Welfare Scheme. This enabled the Basel Mission to establish and operate the Manyemen Leprosy settlement in 1954. It was aimed at battling leprosy in the then Cameroon Province (presently South West Region). Although the British left in 1961 when the territory gained independence, the missionary societies continued with their leprosy elimination campaign. In 1968, the Basel Mission passed the Manyemen Leprosy Settlement to the PCC [5]. From its inception in 1954 to its closure in 1992, the Manyemen Leprosarium engaged in the battle against leprosy in the South West Region that was covered by its activities.

In light of the foregoing, this study contextualizes missionaries' involvement in leprosy work and highlights perceptions towards leprosy in the study area prior to the colonial encounter. It further examines the origins of the Manyemen Leprosy Settlement alongside its leprosy prevention, treatment and socio-economic rehabilitation programmes throughout the period of its existence. The problems and the unexpected closure of the settlement are also discussed. I argue in this paper that the Basel Mission and PCC through the Manyemen Leprosy Settlement

helped not only in significantly reducing leprosy prevalence in Anglophone Cameroon, but rehabilitated sufferers who were disabled by the disease and discriminated upon in their societies.

The Context of Christian Missions' Involvement in Leprosy Work

The role of religion in surmounting the leprosy disease is as old as the disease itself. The doctrines underpinning Islam, Buddhism, Sikhism, Hinduism, Judaism, African Indigenous Religions and Christianity regard kindness and responsibility for the sick, poor and needy as the noblest virtues for followers of these religions to possess. As Navon observes, aiding the ill, the poor and the elderly are meritorious acts embedded in the beliefs of these religions [6]. This constitutes the basis for the involvement of various religious traditions in the improvement of the health of people.

As regards Christianity, lepers in Biblical times were seen as unclean, cast out of their community, and reduced to begging [7]. The Church Council of Ancyra in 314 suggested that leprosy was transmitted through bestiality, causing the segregation of lepers. Amazingly, there are Biblical verses like Mark 2:1-12 and Luke 17:11-19 evidencing how Jesus healed lepers. James Scott notes that "by reaching out to the leper, Jesus made him entirely whole again, not just physically" [8]. These Biblical evidences of leprosy healing urged the clergy and others to minister to the body and souls of leprosy sufferers [9]. So, the involvement of Christian Missionary societies in leprosy work should be placed in the context of the concern Jesus accorded lepers in His time. Indeed, clergymen began interpreting Jesus' healing of leprosy as evidence of both his divinity (in his ability to heal) and his humanity (in stretching out his hand to heal). Consequently, they started decrying the stigmas associated with the disease and encouraged Christians not to despise anyone because of leprosy [10]. Besides, the dreadful deformities of the disease, as Anderson argues, made leprosy sufferers susceptible to the Gospel [11]. Coady complements this line of thinking by stressing that the establishment of leprosaria across the world by missionary societies was aimed at exploiting such a gospel-spreading opportunity [12].

It was therefore the need to yield to Biblical healing doctrines alongside spreading the Gospel that pushed missions to come on board the fight against leprosy. They have played an important role in the care of leprosy sufferers [13]. Christian missionaries drew on leprosy's relationship with Christianity, its debilitating symptoms and the supposed vulnerability of leprosy sufferers in order to mobilise funds from governments and Christians with which leprosy settlements were established. Christians were often told that those who walk with the ill through their painful

journey are fulfilling the Gospel [14]. In most parts of the world, most of the anti-leprosy work was initiated by Christian missionaries. The Basel Missionaries to Cameroon extended their work to the provision of care to lepers by establishing a leprosarium in the territory at Manyemen. Before we discuss the history of this settlement, it is relevant to lay out leprosy perception in the area before the colonial encounter.

Leprosy Perception in the Study Area before the Colonial Encounter

The former South West Province of Cameroon (present-day South West Region) which before 1961 was known as Cameroon Province in British Southern Cameroons constitutes the locale of this study. As an integral part of what is today known as Anglophone Cameroon, the South West Region was the area covered by the leprosy campaign of the Manyemen Leprosy Settlement. The leprosarium itself was located in Manyemen village in the Bangem Sub-Division in the Kupe-Manenguba Division of the South West Region of Cameroon. The leprosarium operated out-patient leprosy clinics throughout the region. The area, because of its relief, is characterized by fragmented societies [15]. The principal ethnic groups in the region are the Banyang and Ejagham in Manyu Division, the Mbo and Bakossi in Kupe-Manenguba Division, the Bangwa in Libealem Division, the Bafaw, Balondo, Bakundu and Balue in Meme Division and the Bakweri in Fako Division. These were the people who were ravaged by leprosy in the area under study.

Prior to the colonial encounter, there were different disease perceptions in the study area that were quite often embedded in the socio-cultural beliefs of the people. As regards leprosy whose origin in the area remains a matter of uncertainty, lepers were marginalized because of its dreadful deformities, misconceptions about the disease and the fear of contagion. This can be likened to the discrimination of lepers in the Indian and Chinese societies [16]. These misconceptions about leprosy that resulted in the social stigma, alienation, and poor treatment of lepers continued in the colonial and post-colonial periods since they were embedded in the cultural beliefs of the people. The indigenes of the area just like in other African societies distinguished between four causes of disease in general: the natural cause equated with acts of the Supreme Being (God), moral infringements, sorcery, and ancestral spirits [17].

Such association of leprosy with divine punishment, incest and witchcraft was common in the South West Region before the colonial encounter. Regarded, therefore, as a shameful disease and supported by the society's belief system, leprosy patients were persecuted and isolated. Disqualified from social acceptance, leprosy sufferers in the area were

crippled by steadily worsening deformities that were visible to the whole community. Besides social exclusion, leprosy often afflicted individuals in their most productive stage of life amounting to the lost of their physical and economic independence [18]. The new dependent status of the sufferers, in spite the stigma, made the impact of leprosy to be felt in entire families and communities [19]. So prior to the colonial encounter, leprosy in the area was characterized by misconceptions, stigma and enormous socio-economic ramifications on individuals, families and communities. This was the precarious situation that pushed missions to develop a feeling of compassion for the helpless and socially excluded sufferers of leprosy. The foregoing perceptions of leprosy in the area are central to this study because they had the potential of influencing the leprosy control programme of the Manyemen Leprosarium. In fact, these perceptions were incorporated into the leprosy control efforts of the Basel Mission in the area with the hope of rolling back stigma and enlisting the indigenes in the fight against the disease.

Historical Roots of the Manyemen Leprosarium

The establishment of the Manyemen Leprosy Settlement was dictated by multiple forces. The prevalence of the disease alongside its injurious effects on the population across Southern Cameroons was one of the contributory factors to the setting up of the settlement. There was no part in the area in which leprosy was not endemic and did not constitute a serious public health problem [20]. The ever increasing number of infected persons was evidence that the incidence of the disease was increasing in many areas of Southern Cameroons, especially the Forest region. Some patients suffered from Lepromatous (the communicable and malignant form of leprosy) while others were carriers of the non-communicable (Tuberculoid type). The ravaging effects of the disease thus became a cause for concern for missions.

Interestingly, leprosy's connections with Christianity alongside doctrinal obligations on followers of the religion to care for the ill provided the potential for missionaries to stream their efforts towards surmounting the disease. The Manyemen Leprosy Settlement partly emerged from this doctrinal context. But it was the German annexation of Cameroon in 1884 that resulted in the extension of Basel Mission activities to the study area. Throughout the period of German rule, combined efforts were made by the colonial government and Basel Mission to tackle leprosy. Unfortunately, the Germans were ousted from Cameroon during World War One amounting to the termination of Basel Mission work. But when the study area was placed under British administration as a League of Nations Mandate in 1922, the Basel Missionaries later returned to the territory in 1925 to

pursue their activities. This coincided with the initiation of leprosy control measures by the British Government in Southern Cameroons. Regrettably, the experimental anti-leprosy work carried out by the colonial government was small and only incidental to general medical work [21] In fact, the fight against the disease was confined to certain areas where it was endemic probably due to lack of funds and qualified personnel. Consequently, the incidence of the disease heightened in many areas of Southern Cameroons in spite of the measures taken by the government [22] According to the Senior Leprosy Officer of the Oji River region in Nigeria, R. H. Bland, the campaign against leprosy in Southern Cameroons lacked coordination in policy and aim [23].

It was only from 1946, following the territories' transition to a United Nations' Trusteeship that the British Colonial Government took new measures to step up the fight against leprosy. The new approach formed part and parcel of the Scheme of Leprosy Control in Nigeria and Cameroon initiated by the Director of Medical Services. Under the scheme, a Leprosy Service was started in Southern Cameroons manned by full-time leprosy service personnel [24] It was decided at that time that full-time leprosy personnel should be stationed in all the four divisions of the territory (Kumba, Mamfe, Victoria and Bamenda). The net outcome of this reform was the unification of policy and coordination of effort which resulted from a unified leprosy service. By spreading the campaign across the territory, the colonial authorities became acquainted with the increasing rate at which the disease was ravaging the population.

Besides, the Cameroon National Federation (a pressure group) submitted a memorandum to the United Nations Organisation Visiting Mission at Kumba on 4 November 1949 in which the British Government was accused for neglecting the leprosy epidemic. The memorandum declared, among other things, that "This terrible disease is extremely rampant particularly in Mamfe Division where some authorities declare that at least 25% of the population is affected." Given that the above memorandum did not yield any fruits, the Mamfe Improvement Union addressed a memorandum to the Resident of Southern Cameroons. The memorandum stressed that leprosy in Mamfe was counted as a group of beasts attacking a helpless band of travelers in the forest. The letter maintained that at least 35% of the population was affected [25] Thus, they stressed the need for immediate attention to be given to the health crisis. The union advised the colonial authorities to encourage missionary bodies (Roman Catholic Mission, Basel Mission and Cameroon Baptist Mission) to open a leper colony in Mamfe Division. In concluding the letter, the union pleaded with the government to consider their worry in these words: "We submit this

therefore in dreadful pains and in an hour where our men, villages and tribes are fading more rapidly into the hands of a foe that our hands cannot measure. The health clock at Mamfe seems to have been standing at one point for over thirty years. Now it is important for the issue of leprosy to be taken seriously" [26].

The above advice on the involvement of missions probably reminded the British authorities of articles 10 and 13 of the 1946 Trusteeship Agreement for the British Cameroons. While article 10 among other things called on Britain to promote the social advancement of the people, article 13 requested the administering power to permit missionary societies to come on board the fight against diseases in the territory. It was at this moment that the colonial authorities saw the need to partnership with missionaries in the fight against leprosy across Southern Cameroons. Consequently, the medical authorities began exploring the possibility of enabling the Basel Mission and Cameroon Baptist Convention to establish leprosy settlements in the territory. This was the main contributory factor to the creation of the Manyemen Leprosarium [27]. From this moment, the government entered into negotiations with the two missions in an effort to associate them in the fight against leprosy. But the two missionary bodies conditioned that they could engage in leprosy control work by opening leper settlements provided government gives regular financial grants.

So, in 1952, the Commissioner for Southern Cameroons in consultation with the Lieutenant Governor of the Eastern Region of Nigeria tabled the conditions given by missionary bodies to the Medical Department of Nigeria. The latter urged R. H. Bland, Officer in charge of Nigeria Leprosy Service, to propose a large scale leprosy control scheme for Nigeria and British Cameroon to be funded by the government. In late 1952, the colonial government adopted the scheme and promised to allot annual funds to missionary bodies involved in the fight against leprosy. It was in this context that the Basel Mission and Cameroon Baptist Mission, by agreement with the colonial government, accepted to be in charge of the leprosy control service in the Cameroons and Bamenda provinces respectively. The activities of these missionary bodies were to be closely supervised by the Senior Leprosy Officer at Oji River in Nigeria. According to the agreement, the government promised a recurrent grant in aid of 2,500 pounds annually to the two bodies. Specific leprosy drugs were also to be given free of charge to them. Further, the government made available a capital grant of 10,000 pounds each to them for the construction of permanent buildings.

On their part, the Basel and Baptist missions were expected to open leprosy settlements in the

Cameroons and Bamenda provinces respectively. They were also supposed to expand leprosy control after the initial establishment of a settlement by way of out-clinics. The authorities of the two churches remarked that the leprosy service had the potential of meeting a long felt need. From early 1952 therefore, the two churches streamed their efforts towards the establishment of leprosy settlements in the areas assigned to them [28]. The Basel Mission commenced the planning phase by engaging in feasibility studies in view of locating an appropriate site. After many places had been inspected, vast unoccupied land in Manyemen, a village located between Kumba and Mamfe, was found apt to host the settlement. The selection of the site was followed by the recruitment of Ries A., a civil engineer, to establish a plan and kick-start the construction of the settlement. After receiving funds from the government in late 1952, the foundation stone was laid in May 1953. The construction of the settlement was completed in 1954. Dr. Frommherz Symark, a German, was appointed by the Basel Mission as manager of the settlement. On 9 January 1955, the settlement was officially opened.

Aims, Organisation and Guiding Principles of the Settlement

It is worth noting that the creation of the Manyemen Leprosarium was the first large-scale attempt to deal with leprosy as a public health problem in the Cameroon Province in particular and in Southern Cameroons in general. Generally, the settlement just like the one opened in Mbingo by the Baptists was expected to survey the area, provide education on leprosy, ensure early case detection and case holding, offer treatment and rehabilitate patients who had lost their economic and physical independence due to deformities. Under the supervision of Leprosy Inspectors, the Basel Mission Leprosarium at Manyemen had to build a network of rural leprosy survey by way of out-clinics planted throughout the province [29]. To achieve these goals, the leprosy settlement needed to be properly organized.

When the Basel Mission accepted to undertake responsibility for leprosy control in the area, she obtained representation in the Eastern Regional Leprosy Advisory Committee in the Eastern Region of Nigeria. The committee handled issues connected with leprosy control in the Eastern Region of Nigeria to which Southern Cameroons was administratively attached [30]. So, the above committee played a supervisory role over the leprosy control work of the Basel Mission.

The ruling bodies of the settlement were: the Leprosy Committee, the Staff Meeting and the Settlement Council. The supreme body of the settlement was the Leprosy Committee. Its membership comprised of the Secretary of the Basel Mission as Chairperson,

two missionaries appointed by the Basel Mission, two representatives of the General Synod, three representatives from Cameroon Native Authorities (each from Kumba, Mamfe and Victoria Divisions), and one representative of the Staff Meeting. The Committee supervised the general administration and planned the general outlay of the settlement. The Staff Meeting handled all internal affairs of the settlement. It ensured the coordination of the work of the various departments and served as a forum for the discussion of issues of common interest. The Staff Meeting saw into it that rulings and instructions of the Eastern Regional Leprosy Advisory Committee and the Leprosy Committee were carried out. It decided in questions of appointment, promotion, disciplinary cases and termination of appointment of junior staff. On its part, the Settlement Council on which all sections of the patients were represented administered the patients' community. The Council met twice monthly. It elected a chairperson from among its members, who represented its interest in the Staff Meeting. The Settlement Council consisted of nine members with the duty of discussing all matters relating to the wellbeing of patients [31]. Another administrative organ of the settlement was the Settlement Police which maintained law and order.

Besides the aforementioned administrative bodies, there was the management which consisted of the employees of the settlement – Medical Officer, Nursing Sister, Manager, staff and workers. The Medical Officer in charge of the settlement was the official representative of the settlement in all outreach activities. He dealt with all matters of specific medical character such as the supervision of medical activities in hospital, laboratory and treatment centres. To add, he decided on the admission and discharge of patients, ordered drugs, bought medical equipment, and assisted the Nursing Sister in the training of nurses. The Manager was responsible for the spiritual care and social welfare of patients. He was in charge of the general administration of the settlement, kept accounts, maintained buildings, supervised patients' farming, water supply, patients' shop and sanitary installations. The settlement was, in light of the foregoing, divided into the general administration, hospital and out-clinics, and various departments.

To ensure that the MLS was successful in its crusade against leprosy some rules and regulations were put in place. These regulations covered various aspects: diagnosis, admission, discharge, treatment and accommodation of patients. As concerns diagnosis, it was made as a rule that all patients coming to the settlement on account of leprosy had to be referred to the Medical Officer who recorded details on the official diagnosis card. Upon admission, patients were expected to maintain themselves in the settlement. Besides,

patients whose admission was approved had to be enrolled and awarded a reference number for easy identification [32]. With regard to the discharge of patients, it was to be approved by the Medical Officer in consultation with the Staff Meeting. Leave from the settlement was backed by a written permit from the Medical Officer which fixed the duration of the leave. As concerns treatment, it was accessible only to properly enrolled patients, and was carried out only at the authorized time and place. Accommodation was also regulated as patients were not allowed to shift from house to house without the permission of the officer in charge of housing. It was forbidden for men and women to share the same house, except married couples. So, there were separate villages for men and women [33] In the domain of religious observations, it was an established rule that the Basel Mission was the official cooperating mission [34] On enrollment, therefore, all patients irrespective of their religious background had to fellowship in the Basel Mission Church.

Leprosy Control Activities of the Leprosarium

The inauguration of the Basel Mission leprosy settlement at Manyemen in 1954 marked the real beginning of leprosy control in present-day South West Region of Cameroon. The settlement was charged with the education of the inhabitants and the detection, treatment and rehabilitation of persons suffering from infectious and non-infectious leprosy. As regards treatment, infectious cases were treated at the settlement while the non-infectious patients received treatment mostly in the out-clinics. The settlement emerged at a time when dapsone enjoyed global recognition as the most effective drug for the treatment of leprosy. Between 1954 and 1982, dapsone was used in the settlement and in all the out-clinics that were attached to it.

The treatment involved the provision of dapsone, dressing of ulcers and many other medical interventions. The patients had to report for treatment at the treatment centre following a time table (plate 1). But after successfully treating and discharging many patients, treatment failures emerged in the settlement in the late 1970s as a result of the resistance of leprosy to dapsone. This was a common occurrence in almost all treatment centres across the globe. It was in this context that the combination of drugs was encouraged by the World Health Organisation (WHO) in view of arresting the disease. The recommendation resulted in the Multi-Drug Treatment (MDT) approach [35] It involved the concurrent use of dapsone, rifampicin and clofazimine. This approach was effective in checking leprosy's resistance to treatment in the settlement. The decline in the number of patients in the settlement was due to the effectiveness of the MDT approach. Those who were successfully cured of the disease were discharged from the settlement and reunited with their families.



Plate 1: Lepers Receive their Tablets at the Manyemen Leprosarium, 1968
Source: Werner Keller, *The History of the Presbyterian Church*, p. 102.

As earlier noted, the administering of drugs was concurrently done with the dressing of ulcers caused by the disease. This explains why the settlement had a well equipped laboratory manned by qualified technicians. They conducted tests in view of finding and treating infections further resulting from the ulcers. It was required that every patient should report to the special ward reserved for the cleaning and dressing of ulcers. To render the treatment of ulcers effective, a Physiotherapy Centre was established in 1967 at the settlement. It was placed under E. Teke who had received training in Ethiopia solely financed by the West Cameroon Government. In 1971, S. Etim was posted to the settlement to assist Teke. The former received thorough training in Nigeria before being recruited at the settlement. The eye deformities witnessed by most sufferers of leprosy necessitated the opening of an Eye Department in 1963 [36]. It was manned by an eye specialist who received patients on a regular basis. Generally, treatment in the settlement helped in reducing the prevalence of contagious leprosy. This was evidenced by the drop in the number of such patients seeking admission. But as we already noted, non-infectious cases were handled in the out-clinics under the supervision of Leprosy Inspectors.

Until 1957, lepers were mainly treated at the Manyemen Leprosarium. After feasibility studies by Leprosy Inspectors, out-patient clinics were opened in the three divisions comprising the Cameroon Province [37]. This innovation enabled the leprosy control work in the area to be felt outside the confines of the settlement. These leprosy clinics were seated at strategic places in each of the three divisions: Kumba,

Mamfe and Victoria. Vehicles were bought to enable the doctors at Manyemen to tour from clinic to clinic in each of the three divisions [38]. At the same time, twenty-four Southern Cameroonians were trained as Assistant Leprosy Inspectors in the Leprosy Inspector Training School at Oji River in Nigeria in 1956 [39]. They were stationed in the divisions to manage out-clinics. The Manager of the Manyemen Leprosarium, Dr. Sybank, provided the necessary instruments and requisites needed in the clinics. They were forceps, scissors, ointments, bandages, cotton wool, and drugs. Since only non-contagious cases were admitted in the out-clinics, the inspectors were instructed to refer all contagious cases to the settlement. They identified new patients and placed them on treatment. These clinics were visited twice every year by medical doctors from the settlement.

In the Mamfe Division, Boteher, an Assistant Leprosy Inspector, was very active in opening and supervising out-clinics. Generally, the Mamfe Division which had the highest prevalence rate in the region had six out-clinics catering for over 1000 patients. The clinics were seated in villages like Bachuntai, Mbinjong, Etuku, Tali, Bakebe and Sumbe [40]. With regard to the Kumba Division, out-clinic work was much better organized. The four full-time Leprosy Inspectors cooperated well resulting in the opening of clinics in places like Bakundu, Kurume, Bafo, Bole Bakundu and Bayi. As regards the Victoria Division, the principal clinics were found in Bota, Ekona Mbenge and Lysoka. Following the eventual involvement of the settlement in the training of Leprosy Inspectors, the number of out-clinics increased. By 1961, there were

104 leprosy clinics attached to the settlement. The clinics catered for over 3600 patients.

The increase in the number of clinics made supervision by doctors from the settlement extremely difficult. In his letter to the Principal Medical Officer of Victoria Division, the Manager of the Manyemen Leprosarium noted that the settlement was unable to effectively supervise the clinics since the exercise required heavy amounts of money. This urged the West Cameroon Government to provide four Land Rovers and two ambulances to ease out-patient clinic visits and supervision. The supervision of out-clinics by leprosy inspectors was also done by the use of bicycles. The problems accruing from the supervision of the clinics pushed the authorities of the settlement to negotiate with the West Cameroon Government on the possibility of placing some clinics under her supervision. Consequently, it was reached in 1962 that the leprosarium be responsible for clinics only within an area of roughly 30 miles radius from the settlement [41]. The clinics that were taken over by the Federal Government were placed directly under the Department of Major Endemic Diseases and Rural Medicine (DMEDRM) with headquarters in Yaounde. Thus, the burden of supervising out-clinics in the Forest Region was shared between the government and the settlement [42].

Overall, many patients were successfully treated either in the clinics or in the settlement. Irrefutably, all these beneficial treatment efforts only touched a fringe of the problem. As earlier noted, misconceptions about the disease resulted in the stigmatization and social exclusion of patients. It was not therefore enough to treat patients while new infections kept increasing. It was in this context that the Manyemen Leprosarium just like other leprosy colonies in the world saw prevention as an approach worth pursuing.

Throughout the existence of the settlement, health education was provided in view of explaining the true facts about leprosy. In fact, the authorities of the settlement incorporated socio-cultural beliefs into their leprosy control programme with the hope of increasing effectiveness in prevention, early case detection and in rolling back the social exclusion of lepers. Further, the local population was ceaselessly told to report all cases of leprosy to the medical authorities in view of admitting them in clinics or at the settlement. The overall purpose of the preventive sensitization campaign was to involve every man and woman and boy and girl in the battle against leprosy. The population, thanks to the sensitization, became involved in the struggle against leprosy by spreading the information that if leprosy cases are treated at an early stage, the chances of cure without deformities are

maximized. In the settlement itself, the authorities made provision for pipe borne water and laid emphasis on the strict respect of hygiene and sanitation rules. In order to improve the diet of the patients, they opened farms wherein diverse food crops were cultivated. As a matter of fact, multiple socio-economic activities such as the opening of a primary school and a chapel in the settlement alongside the enhancement of agriculture, hunting, craft work, etc. were encouraged as a means of ameliorating the livelihood of the patients.

What emerges from the foregoing is that the authorities of the Manyemen Leprosy Settlement employed an innovative and holistic approach in their leprosy work in the area under study. This holistic approach which can be likened to the leprosy control efforts in leprosaria in India, Nigeria and South Africa involved survey, education, treatment and rehabilitation. It was thanks to survey and educative efforts that the delay between the onset of the disease and its detection was surmounted. By successfully dispelling stigma and providing facts about the disease, early case detection became possible. This resulted in the treatment of thousands of lepers at the Manyemen Leprosy Settlement as well as in its over 100 leprosy clinics. Besides, the social exclusion of leprosy sufferers in communities across the area was significantly reduced. Given that some patients ended up with various disabilities after receiving treatment, the leprosarium authorities took gainful measures to provide physical and socio-economic rehabilitation. Across the region, treated lepers did not only regain their physical and economic independence, but also became recognized in an inclusive manner in their societies. In spite these gains, a plethora of problems culminated in the closure of the leprosarium in 1992 when the eradication of leprosy in the area had not been attained.

Problems and Closure of the Leprosarium

A multitude of problems impeded the Manyemen Leprosy Settlement from meeting some of its goals and provided the potential for its closure. These constraints evolved with time and circumstances and ranged from theft, indiscipline, mismanagement, to financial difficulties. The stealing of property and money was a serious problem encountered by the Manyemen Leprosy Settlement. This was mostly carried out by patients who either stole from the farms owned by the settlement, from staff, or from other patients. Problems connected with theft were handled by the Settlement Council. For example, Timothy Eta, Jemo Epamby and Mupoko Dioko were dismissed from the settlement in 1957 because of stealing [43].

As regards indiscipline, the rules and regulations of the settlement were often violated by the patients, which made it difficult for the workers to have

total control over them. It is necessary to state that the respect of the settlement's rules had the potential of easing its management alongside the attainment of its goals. This explains why severe measures were always taken against all those who were involved in acts of indiscipline. The principle that was quite often disregarded by patients was the obligation placed on them to take permission before leaving the settlement no matter the reason. For example, Philip Mbiap, Elias Eyasa, Hans Eta, Moses Etang and John Tanyi were dismissed from the settlement in 1968 for leaving the settlement without permission. The danger connected with this act of indiscipline was that these patients were suffering from contagious leprosy which could easily be transmitted. There was also the problem of adultery involving patients and patients, patients and workers and workers among themselves. In 1962, the assistant Overseer, Oscar Ndiike, was found guilty of committing adultery with Elomba, a female leper [44]. Leaning on the rules of the settlement, a decision was taken to dismiss Ndiike from the settlement.

The mismanagement of funds, drugs and equipment was in itself a very serious problem for the settlement. In fact, the collective interest of the patients and the settlement was at times out-weighed by individual interest. In February 1962 for instance, a Leprosy Inspector, Raymond Joseph Eyongmboh, mismanaged some drugs that were destined for out-clinics. Consequently, Eyongmboh was sacked and replaced by Stephen Etim [45]. This misuse of resources undeniably had a negative bearing on the functioning of the settlement. The settlement also encountered financial difficulties largely resulting from the Basel Mission's transfer of the settlement to the PCC in 1968. Prior to this, the funds with which the settlement was run were significantly allotted by the Basel Mission. The Presbyterian Church found it difficult to raise the funds required for the proper functioning of the settlement. In the 1970s, the problem of financial insufficiency aggravated when the church was engulfed by a financial crisis caused by a new labour code instituted by the Cameroon Government [46].

Thus, the financial crisis lived by the settlement in the early 1970s was a spillover of the serious financial dilemma that engulfed the PCC. Indeed, the PCC reduced the annual grant to the settlement from two million francs CFA to 1.5 million francs CFA. Also, a controversial decision to close the kitchen and school was taken by the Medical Board. But fierce criticisms from various quarters caused the decision to be reversed. Further, efforts were made to limit the number of patients in the settlement aimed at reducing the number of staff. This certainly explains why ninety patients who had not completed their treatment were discharged in 1974. The authorities of

the settlement found it difficult to pay the salaries of its workers, maintain equipment, afford drugs, and to carry out proper supervision work in the out-clinics. The problem was acute to the point that the authorities of the settlement and the PCC had to seek measures to address it.

After acknowledging the cancerous nature of financial insufficiency, the Moderator of the PCC, Right Reverend J. C. Kangsen, approached the Basel Mission in view of finding a solution. The PCC-Basel Mission talks caused the latter to accept to solely finance the settlement for a period of five years, that is, from 1973 through 1978. This was how the financial crisis was managed thereby enabling the authorities of the settlement to effectively carry out their activities. But after 1978 following the termination of Basel Mission grants, the financial crisis resurfaced. And a few years later when Cameroon was visited by an economic crisis, the situation further aggravated. It became impossible for the PCC to pay workers salaries and to continue with the settlement's leprosy control activities: survey, education, treatment and rehabilitation. By 1990, many of the settlement's out-clinics had been closed. As the crisis persisted, the authorities of the PCC resolved to close the leprosarium in 1992. From this moment, PCC's leprosy work in the region was integrated into the general health service of the Presbyterian Hospital at Manyemen that was (and still is) located at about 400 meters from the defunct leprosarium. Presently, there is a Leprosy Department in this hospital that handles leprosy patients. Regrettably, survey, education and rehabilitation efforts ceased in 1992.

Although the settlement was closed, some patients who had serious deformities accruing from leprosy and who could not return to their homes continued living in some of the buildings of the defunct leprosarium. After staying there for two decades, the twelve aging lepers were forced out of the befitting settlement structures by the authorities of the PCC in late 2012. The PCC handed all the buildings to a company that goes by the name HERAKLES FARMS SG Sustainable Oils Cameroon Ltd. in 2012. This company indulges in activities that have no connection with leprosy work. In fact the decision to hand-over the buildings to this company was problematic given that there are still cases of leprosy in the area. Worse still, Nemoh Stephen who was/is in charge of the Leprosy Department was not consulted by the authorities of the PCC before taking the controversial decision. Nemoh noted in an interview that he only saw the workers of the company taking over the buildings and regretted the destruction of documents relating to leprosy work. This is certainly an act of mismanagement since these buildings were set up for the purpose of leprosy control. Even more disturbing is the fact that the aging patients

who could not be rehabilitated were ejected from the buildings. Faced with this situation, Nemoh resettled them in some of the abandoned kitchens in the Presbyterian Hospital Manyemen [47]. This rendered life even more difficult for these disabled old men and women.

CONCLUSION

This study has used the Manyemen Leprosarium as a case study to examine the emulation of Jesus' loving-kindness towards lepers by Christian churches in Anglophone Cameroon. The paper reveals that apart from their involvement in the prevention of the disease, they encouraged early case detection, case holding in settlements and consequently, the curing and rehabilitation of many lepers. Although financial crisis and the reform on the integration of leprosy work into general health service amounted to the closure of the leprosarium in 1992, it contributed in the elimination of leprosy as a public health problem in the present-day South West Region in particular and Anglophone Cameroon in general. Since the closure of the leprosy settlement, as the study further reveals, PCC's leprosy work in the area became integrated into the general health service of the Presbyterian Hospital at Manyemen. The integration of leprosy work into general health care is a general trend that resulted from recommendations made by the WHO. Thus, the closure of the Manyemen Leprosarium was not an isolated episode given that the above reform also affected mission-run leprosaria in Nigeria, South Africa and India among others. But the ejection of disabled lepers from the buildings of the defunct Manyemen Leprosarium by PCC authorities remains problematic. This has worsened the already bad situation of these physically and economically dependent people. Considering the persistence of the disease in the area in spite its reduced prevalence, there is need for more leprosy experts to be recruited in the Leprosy Department at the Presbyterian Hospital Manyemen so as to sustain the leprosy campaign.

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