

**COLONIAL LEGACIES IN DISEASE CONTROL: HEALTH
INSTITUTIONS AND THE BATTLE AGAINST LEPROSY AND
TUBERCULOSIS IN TARABA, NIGERIA (1900–2025)**

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ABSTRACT

Diseases, epidemics, and healthcare provisioning are intrinsic attributes of human society since prehistoric times. Human beings and societies have had to deal with various diseases (including infectious ailments) that adversely affect human socialization and development by devising ways to forestall, treat, or prevent the relapse or escalation of such diseases. In post-colonial Nigeria, infectious diseases such as leprosy and tuberculosis posed serious health threats to national development. The Federal Ministry of Health posits that by 2017, there were 418,000 tuberculosis cases in Nigeria. The figure rose to 429,000 in 2018. By 2020, Nigeria had the 6th highest TB burden globally. Although there have been efforts to curtail its endemic prevalence, particularly in Taraba State, which is the focus of this study, the challenge persists. There has been a dearth of historical scholarship on this subject aimed at understanding the historical dynamics of the treatment and management of infectious diseases such as leprosy and tuberculosis in Taraba State. This study examines the manifestation of colonial legacies in the post-colonial dynamics for the prevention and control of leprosy and tuberculosis and the development of public health institutions in Taraba State, Nigeria, from 1900 to 2025. The study primarily adopts the historical methodology, employing primary sources such as oral interviews, official documents, and archival data, as well as secondary sources such as published books and scholarly journals. The study reveals that Christian missionary efforts, government healthcare initiatives, and local adaptations intersected to shape healthcare access, infectious disease control, and the

training of indigenous health personnel during the colonial period. Further, the study reveals that the colonial legacy and semblances of the colonial era significantly influence the management and control of infectious diseases such as leprosy and tuberculosis in the contemporary period in Taraba State, although contemporary challenges such as infrastructure, corruption, and funding have worsened the conditions of the health facilities responsible for controlling such diseases. The study recommends that the positive legacies of the colonial infectious disease control, such as the establishment of health centres, should be prioritised, and the negative legacies should be jettisoned.

KEYWORDS: Tuberculosis, Leprosy, Health, Disease Control, and Infectious.

INTRODUCTION

Diseases, epidemics, and methods of healthcare provisioning are intrinsic attributes of human society since prehistoric times. Human beings and societies have had to deal with various diseases (including infectious ailments) that adversely affect human socialization and development by devising ways to forestall, treat, or prevent the relapse or escalation of such diseases (Laura, 2016). In other words, epidemics are not contemporary phenomena, and there have been ways of preventing, treating, and managing their impact for centuries, although the type and nature of the epidemics and methods of controlling and managing their impact differed from one geographical area to another and from one historical epoch to another.

Even before the advent of colonialism, Africans had encountered various ailments and epidemics, some of which include sleeping sickness, human trypanosomiasis, and malaria caused by *plasmodium falciparum*, among many other ailments. To be sure Africans had methods of controlling and managing these ailments. Doyle (2025) argued that these methods, mastered by herbalists, *juju* men, witchdoctors, or ‘*Babalawo*’ as they were called, combined herbs, surgical methods, and spirit invocation in preventing sicknesses, treating the sick, and curtailing escalation. The slave trade and legitimate trade eras introduced ailments such as cholera, dysentery, influenza, measles, and influenza to the continent as there were interactions with people from outside the continent.

The interaction between Africans and the outside world increased in the colonial period. The early colonialists could not withstand the diseases in Africa, so the continent was referred to as the “white man’s grave”. It was reported that half of

the missionaries who arrived the Gold Coast in 1850 died within a year, although medical discoveries and the establishment of hospitals improved the mortality in the 1850s and 1890s. These improvements in medicine and the establishment of health centres were done by the colonial governments and the missionaries. To buttress the point, by 1925, there were over 116 missionary hospitals and 366 dispensaries in sub-Saharan Africa (Wright, 2018). Healthcare provisioning was a strategy for the evangelisation of the people. In the Congo area, the burden of healthcare provisioning, disease management, and prevention was handed over to the missionaries, while the Francophone countries depended on military doctors (Houegot, 2019).

In the area which later became Nigeria and Taraba State in particular, medical interventions during the colonial period were initially designed to serve European administrators and missionaries. According to Edgar (1972), with the expansion of missionary work and Native Authority governance, health services gradually extended to the indigenous population. It has been posited that colonial public health policies were shaped not only by scientific progress but also by imperial economic interests to guarantee the supply of a healthy manpower for colonial exploitation. This development was marked by the establishment of more healthcare centres and dispensaries (for treatment) and the setting up of research centres for the training of health personnel by missionaries and the colonial government. Infectious epidemics such as leprosy and tuberculosis, which had inspired religious and social interpretations among African communities since the pre-colonial period, received scientific intervention during colonial times (IOM, 2018). The scientific interventions generally improved the management and control of these infectious diseases. This paper argues that although there have been changes, there are observable similarities between the colonial and post-colonial methods of controlling infectious diseases such as tuberculosis and leprosy in Nigeria and Taraba in particular. Further, the paper submits that adequately construing the colonial legacies in tuberculosis and leprosy management is essential in managing the epidemics in the contemporary period. This study is relevant considering the exponential increase in incidences of leprosy and tuberculosis in Nigeria and Taraba State in particular.

AIM AND OBJECTIVES OF THE STUDY

The primary aim of this paper is to account for the colonial legacies in the contemporary methods for the control and management of infectious diseases such

as tuberculosis and leprosy in Taraba State, northeastern Nigeria. The objectives of the paper include the following:

1. To historicize the dynamics in the control and management of infectious diseases such as tuberculosis and leprosy in Taraba State.
2. To comparatively analyse the colonial legacies in the contemporary dynamics of tuberculosis and leprosy prevention, management, and control in Taraba State.
3. To interrogate the achievements and limitations in the tuberculosis and leprosy control methods in Taraba State and suggest the way forward.

LITERATURE ON COLONIAL LEGACIES IN DISEASE CONTROL

There is a significant body of extant literature on the history of colonial healthcare delivery and its nature in the post-colonial period in Africa. The extant literature provides insight into this current study on the legacy or transformation of the dynamics of tuberculosis and leprosy management in Nigeria and Taraba State in particular. Some of the extant literature is reviewed hereunder for the purpose of this research. Cochrane (2022), for example, construed the influence of colonialism on contemporary healthcare management in Africa in his study, *Colonial Entanglements in African Health Worlds*. He argued that due to the far-reaching impact of colonialism on Africa, its legacy remained visible in the post-independence period in almost all areas; hence, understanding the colonial period is essential for understanding the contemporary period. In the healthcare sector, Thandeka remarked that the colonial era system whereby the missionaries and government were heavily involved in the disease control and training of personnel persists in the contemporary period with little variation. Thandeka's work is relevant to this research as it articulates the transformation in the process of healthcare provisioning. Thandeka premised his argument on the point that the major hospitals in contemporary Malawi were missionary creations during the colonial period and still serve important purposes. Thandeka's work, focusing on Malawi, contextually differs from the current research, which considers Taraba State; however, the arguments will be valuable to the current study.

Boateng-Ade (2022) considers a subject relevant to this current study. She lamented the disastrous state of contemporary healthcare in Africa, characterized by inequity in access to healthcare, high cost of healthcare, poor state of public hospitals, and high mortality rates. Boateng-Ade asserted that while several factors,

including corruption, may be responsible for the deplorable state of healthcare, the root cause of the poor state of healthcare stems from colonialism, as the approach adopted by the colonialists and the missionaries to healthcare provision benefited some social groups (elites) and did not benefit the masses in general. She further argued that the systems introduced class stratification in the provision of healthcare, a development alien to Africans and their system of health. Like Thandeka (2022), Boateng-Ade's (2022) work is valuable to this current research, but the contextual scopes differ. Also, this current study specifically focuses on the colonial legacies in the management of infectious diseases such as tuberculosis and leprosy in Taraba State of Nigeria.

Hokkanen (2017) suggested that one of the major legacies of colonialism on healthcare in Africa was the transformation from traditional African medicines to conventional Western medicine. He reiterated the critical role played by missionary societies such as the Church Missionary Society (CMS), the Roman Catholic Missions (RCM), and the Baptist Missions, among others, in introducing conventional medicine and healthcare in Africa (Hokkanen, 2017). The introduction of the new medical systems replaced the African traditional medical systems and relegated the African healthcare systems. Further, the missionaries were selective in delivering healthcare to the people as they only provided quality care for the Europeans and Africans who were willing to convert to Christianity, while the natives only got limited medical attention. The new healthcare system introduced classism in the African society, a new development. This system persisted in the post-colonial period, affecting the healthcare system in Africa. His arguments are valid and may be applied in the context of this current study in understanding the colonial legacies in tuberculosis and leprosy control in Nigeria.

COLONIAL HEALTH INSTITUTIONS AND INFECTIOUS DISEASE CONTROL IN NORTHERN TARABA

In Northern Taraba, the colonial government and missionary organizations collaborated in healthcare provision, primarily to support colonial administration. Falola (2025) has argued that the colonial government's support for health institutions was not strictly aimed at developing colonial Nigeria; the colonial government supported the health institutions to ensure the convenience and safety of the colonial administrators and to ensure their treatment. The missionaries were also very active in the establishment of health facilities in the Nigerian area during the

colonial period, as such facilities were useful in the training of missionaries who took ill during the missionary journeys. Raymond (1990) established that in present-day northern Taraba State, health institutions were operated by Catholic Missionary congregations as clinics with specific units for treating infectious diseases, and which played a key role in controlling such communicable diseases.

Between 1953 and 1959, Native Authorities in northern Taraba established several health dispensaries following the directives of the colonial government. Although intended to serve broader populations, these facilities were primarily aimed at controlling outbreaks that could affect colonial officers, as Falola (2025) argued. These hospitals—including Bambur, Lankaviri, Zinna, and Karim-Lamido—were poorly equipped and lacked sufficient medical personnel (Min. of Health Annual Reports, 1961).

Despite limited resources, these institutions laid the foundation for medical infrastructure in the region. By the post-colonial era, these health outlets evolved from basic dispensaries into more comprehensive health centres, providing not only curative services but also preventive measures such as immunization and health education. For emphasis, St. Monica Health Centre in Yakoko was established in 1965 by the Franciscan Missionary Sisters. The centre was supported by international donors with specialized units for tuberculosis and leprosy care and became a hub for training indigenous healthcare workers. According to Houéto (2019), the health centres established during this period had specialized units for the care and treatment of leprosy and tuberculosis, as was the case in the health centres in Taraba North.

Central Taraba: The Kuturu Health Centre and Its Missionary Legacy

Central Taraba's Kuturu Health Centre was founded in 1948 by Christian missionaries, becoming a cornerstone in leprosy care. The hospital gained prominence through the work of Dr. Roy Pfaltzgraff, a medical missionary who introduced multidrug therapy (MDT) during his tenure from 1954 to 1982 (Barminus, 2003). The Kuturu Centre provided clinical treatment, surgical rehabilitation, and prosthetic services, positioning it as a regional hub for leprosy and dermatology. Its operations were primarily supported by international missionary organizations, but the Centre also fostered local engagement through basic medical training of indigenous staff (Barminus, Oral Interview, February 2nd, 23).

However, with the transfer of control to the defunct Gongola State in 1976 and the creation of Taraba State in 1991, institutional support declined. Geographic

isolation and funding gaps contributed to its eventual dilapidation. Despite its decline, the Kuturu Health Centre remains an important historical site. It demonstrates the impact of missionary medicine and the necessity of sustained investment in public health infrastructure beyond philanthropic and religious motivations.

Southern Taraba: The Dual Mission of Tamia Health Centre

The Tamia Health Centre, established in 1950 by the Sudan United Mission, served dual functions as a medical facility and evangelical base. Named after a philanthropist, the centre addressed diseases like leprosy, tuberculosis, and malaria while simultaneously spreading Christian teachings (Musa, Oral Interview, July 24th, 2022).

The Tamia Health Centre stood out for its early integration of health and religious outreach, which helped reduce stigma surrounding disease. The missionaries at the Tamia Health Centre provided medical treatment, community education, and support for communities within its area of operation. Its campaigns were aimed at correcting the wrong societal belief that diseases like leprosy were punishments from the gods and that lepers were damned people who did not deserve any help. The belief that these sets of people were paying for the sins of their forefathers made access to healthcare very difficult for them (Interview with Sale, August 2025).

The Sudan United Missions operated the health facility from its creation in the 1950s up to the postcolonial period. The health centre was later handed over to the local churches and the Takum Native Authority. Following this handing over, the operations of the health centre deteriorated. This was reflected in the poor staffing, inadequate facilities, and low morale among personnel caused by the poor remuneration, which reduced the effectiveness of the health centre. The situation was such that by the early 1990s, the health centre had become largely non-functional (Samuel, Oral Interview, July 26th, 2022).

The Urban Model: Jalingo Township Health Centre

Founded in 1938 by the Jalingo Native Authority, the Jalingo Township Health Centre became the oldest and most influential health institution in the Jalingo area. Initially established as a Native Dispensary in the mid-colonial period, the Jalingo Township Health Centre evolved into a primary healthcare centre that addressed diseases such as tuberculosis, leprosy, and smallpox (Tafida, Oral

Interview, July 1st, 2022). The health centre remained a government health centre during the colonial period providing healthcare to the natives during the colonial period.

The Jalingo Township Health Centre benefited under Nigeria's post-independence health policies, especially during the 1970s and 1980s. The National Development Plans, such as the Basic Health Services Scheme, was beneficial to the health centre in terms of grants and other forms of support. The recognition of the Jalingo Township Health Centre under the Nigeria State Health Investment Project (NSHIP) marked a turning point in the local health service delivery of the health centre. The facility became a model for integrating national and global health initiatives at the grassroots level (Haruna, Oral Interview, July 3rd, 2022).

Training and Capacity Building

The training of indigenous health personnel was pivotal to sustaining healthcare delivery across Taraba during the period under study. Missionary institutions like St. Monica, Tamia, and Kuturu pioneered basic training programs for nurses, health attendants, and laboratory staff. These programs, although rudimentary, laid the groundwork for more formal training opportunities introduced by the government in the 1970s (Sale, Oral Interview, August 19th, 2025).

Institutions in Kano and Zaria began producing certified healthcare professionals, while internal mentoring continued in other local health centres. For instance, the Jalingo Township Health Centre became known for producing skilled auxiliary staff, some of whom later transitioned into official state health services (Sale, Oral Interview, August 19th, 2025).

Disease Prevention and Public Health Strategies

The colonial government adopted various strategies for the control and prevention of diseases. Public health strategies in colonial Taraba prioritized leprosy and tuberculosis control due to their contagious nature and potential to undermine the colonial order. Early strategies focused on isolation, segregation, and rudimentary treatment, often delivered through missionary outposts. The isolation of the infected patients in Taraba State was aimed at limiting the contacts and mitigating the spread of the virus (Sale, Oral Interview, August 19th, 2025).

There was a slight change in the prevention strategies during the post-colonial period with the advent of antibiotics and MDT in the 1960s. The treatment of these diseases became more effective, allowing for outpatient care, community reintegration, and lesser segregation of the patients (Interview with Gamisa, August

2025). Surveillance, health education, and regular field visits became essential tools in containing the spread of these diseases (Interview with Abel, August 2025). There were periods when community health workers conducted door-to-door visits and administered drugs to affected individuals.

HEALTH INFRASTRUCTURE AND RESOURCE CHALLENGES

The leprosy and tuberculosis control strategies of the government were affected by various challenges, which limited its achievements. One of the most persistent challenges in Taraba's health history was the challenge of inadequate infrastructure. Some of the facilities began as small, mud buildings with minimal equipment and could not be improved during most of the colonial period because of the lack of funds (Sale, Oral Interview, August 19th, 2025). Although missionaries attempted to maintain standards through international donations, sustainability was often lacking (Duarte et al., 2021).

The infrastructural challenges that limited the proper functioning of the health facilities in Taraba included the challenge of power supply, water access, drug storage, and inconsistent equipment procurement. For emphasis, solar refrigerators were used to store temperature-sensitive vaccines in places like Yakoko and Kuturu, but maintenance was irregular. Furthermore, there was also a logistics challenge as vehicles used for fieldwork frequently broke down, limiting the outreach services of the health facilities. Such vehicles remained in a state of disrepair for a long time as there was no funding to fix them (Gamisa, Oral Interview, August 19th, 2025).

In summary, challenges such as financial limitations, infrastructure decay, and social stigmatization of healthcare roles (particularly in leprosy care) limited the pool of trainees. The limited budgetary commitment from both colonial and post-colonial governments further compounded matters, frustrating the efforts of the health workers. The stigmatization of the health workers in the leprosy centres and the poor treatment of health workers persisted; many of whom ultimately took to other professions (Sale, Oral Interview, August 19th, 2025). Many facilities relied heavily on mission funds or donor aids, which fluctuated based on foreign interest and organizational priorities. Due to the challenges, some of the health facilities have shut down as they cannot afford the running costs.

CONCLUSION

This study has examined the colonial legacies in the control of infectious diseases such as tuberculosis and leprosy in Taraba State, Nigeria, from the colonial

period to the contemporary period. The study considered the history of infectious diseases and explored the achievements, changes, and limitations in the process. The study arrived at some conclusions, principal of which is that the history of conventional infectious disease control in Taraba can be traced to colonial healthcare institutions in Taraba State. Such health institutions represent a complex interplay of imperial interests, missionary zeal, and indigenous adaptation. While they introduced important disease control strategies and established the foundation for modern health services, the colonial health centres promoted classism, as most of the main health centres were not established for the general good of the locals but for the convenience of the expatriates.

The contributions of these health institutions in infectious disease control can be considered manifold. First, the health institutions were actively engaged in creating public health awareness, training local personnel, and the reduction of disease burden in targeted areas. The efforts of the colonial health institutions were thus short-term and long-term, as seen in their training of personnel. Some of the colonial legacies of the health institutions were abandoned in the post-colonial period. The history and efforts of the colonial health institutions offer valuable lessons for contemporary health policy in Nigeria in general and Taraba State in particular, emphasizing the importance of sustainable infrastructure, community engagement, and the integration of traditional beliefs in health planning.

Though essential in disease control, the long-term impact of these health institutions in the post-colonial period was marred by structural weaknesses and sociocultural barriers. Several factors limited the contributions of the colonial health centres; challenges that deepened in the post-colonial period. The health centres faced challenges ranging from the shortage of funds, inadequacy of infrastructures, logistical challenges, and the stigmatization of health workers in leprosy centres. The persistence or worsening of these challenges during the post-colonial period ultimately led to the closure of some of the health centres that had existed since the colonial period.

RECOMMENDATIONS

After an examination of the methods, contributions, and challenges of infectious disease control in Taraba State from the colonial period to the present, this study makes the following recommendations:

1. There is a need for the revival of the infectious disease control centres in all the regions in Taraba State to mitigate the prevalence of infectious diseases.
2. The government should prioritize the training of medical personnel specialized in infectious disease control in the higher institutions.
3. The government should set up a fund aimed at meeting the financial demands of the health centres.
4. Considering the persistence of wrong social stereotypes on infectious diseases, the government needs to undertake an aggressive orientation campaign aimed at correcting some of the false stereotypes. The radio and physical outreaches are recommended for this campaign.

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INTERVIEWS

S/N	Name of informant (s)	Occupation	Age	Place of interview	Date
1.	Barminus, A. G.	Retiree	70	Garkida	13.02.23
2.	Musa, M.	Farmer	60	Ussa	24.07.22
3.	Hamisu, Sale	Civil Servant	55	Jos	19.08.25
4.	Samuel, K.	Medical Doctor	59	Ussa	26.07.22.
5.	Tafida, U.S.	Lecture	43	Jalingo	1.07.22.
6.	Haruna, A.	Businessman	60	Jalingo	3.07.22.
7.	Joseph, Gamisa	Nurse	35	Jos	19.08.25