INTRODUCTORY EDITORIAL NOTE

Two of the objects of the British Empire Leprosy Relief Association are to study leprosy as it occurs in the various territories of the Empire, and to advise Governments, missionaries and others concerned as to the best methods of dealing with the disease.

With this in view Mr. Oldrieve, the original secretary of the Association, made an extensive tour in Africa in 1927, and Dr. Cochrane, then the Medical Secretary, visited the countries of East and South Africa in 1930.

In continuation of these tours, and on the invitation of the Colonial Office and various Local Governments, the Medical Secretary of the Association spent over six months of 1938 visiting various countries, especially in East Africa. In each country visited there was an opportunity of discussing leprosy and related subjects with the medical, administrative and other authorities, as well as with missionaries and those engaged directly in anti-leprosy work.

The findings in each country, along with suggestions put forward, are embodied in separate reports, copies of which were sent to all directly concerned. A desire has been expressed by the Medical Adviser to the Colonial Office and by others who have read these reports that they should be published in book form, so that they may be more widely circulated and remain on record.

They have therefore been embodied in the current *East African Number.* The reader will find the reports arranged in the order of countries visited—Malta, Anglo-Egyptian Sudan, Belgian Congo, Uganda, Kenya, Tanganyika, Zanzibar, Aden, British Somaliland. Egypt was also visited in connection with the International Congress of Leprosy, reports of which have appeared in the last two issues of the *Leprosy Review.* The Malta and Aden reports, though not belonging to East Africa, have been inserted as these places were included in the itinerary. Some photographs taken during the tour have been added to illustrate matters mentioned in the text.

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Taking north east Africa as a whole and studying the countries referred to, the southern Sudan appears to be almost the only part to have escaped serious infection. This is possibly on account of the sparseness of the population, their nomadic life, the difficulty of communications and the consequently less close mixing of the people with one another. The diet of the nomad, with its milk

and occasional meat, has also been suggested as a cause of their comparative freedom from the disease. But perhaps as important a factor as any is the hard life they live which is against the survival of the unfit, the leper tending to fall out quickly before he can spread infection to any great extent.

An area of high endemicity centres in the North West part of the Belgian Congo and extends over the Equatorial Province of the Sudan, and the western part of Uganda. The most of the Buganda Province of Uganda is comparatively free from leprosy, doubtless on account of the intelligence, education and activity of the people. But again in the east of Uganda and the neighbouring Kavirondo District of Kenya Colony, round Mt. Elgon and the north-east shores of Lake Victoria, leprosy is very rife. Among the active natives of the Kenya uplands and mountains leprosy is not very common, but among the Wadigo and Wadaruma of the coast it again increases in amount. While leprosy is found in almost all parts of Tanganyika Territory, it appears to be most common in the Southern Province.

A curious phenomenon was noticed: the severity of leprosy in an area does not always correspond with its frequency. This is particularly remarked on in the Congo report. It would appear as if the promiscuity and insanitary habits of the people led to a very widespread infection, even those with higher degrees of natural resistance acquiring the disease, though in a comparatively mild and often abortive form; whereas in more sanitary surroundings and with less frequent and close contacts only the less resistant members of the community acquire the disease, and the proportion of severe cases is greater. An alternative explanation is that the Central African strain of leprosy bacillus may be of a milder nature than that found elsewhere. It would be interesting to know what proportion of mild cases prove abortive, and if there is a direct ratio between the proportion of mild cases and that of abortive cases. The repeated and extensive surveys of the Belgian *Croix Rouge,* made at intervals of one or two years, should bring out some important findings bearing on these two questions.

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As elsewhere, the bulk of anti-leprosy work is being done by religious missions, the funds being chiefly supplied by Government or Native Administrations. Among the exceptions to this are the excellent Government settlement at Li Rangu in the Equatorial Sudan, the well-run camp at Kakamega in Kenya, and the smaller camps at Msambweni (Kenya), Dar-es-Salaam, Zanzibar and Berbera (Somaliland).

The first essential for a successful leprosy institution in Africa is a whole-time expert enthusiastic worker, whether it be doctor, nurse or lay worker. The second essential is building up on a voluntary system an institution where cheerfulness, usefulness and hopefulness are the outstanding characteristics. The most striking instance of such work is that of Miss Laing at Kumi and Ongino.

The place of religious missions in anti-leprosy work is a most important one, as it calls for sacrifice, patience and high ideals. Wherever I went I was impressed by the selfless devotion of those who had given their lives to this work. On the other hand, occasionally religious bigotry and narrow self-interests were blighting, or at least hampering, work which would otherwise have been of the first order.

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Much has been said for and against the leprosy *out-patient clinic*. Often too much reliance is laid on injections of chaulmoogra, as if this drug had a specific effect and would benefit the patient whatever his general health; whereas, if the patient is undernourished or is weak with complicating conditions, the walk to the distant clinic or even treatment with injections may be positively harmful.

But under certain circumstances out-patient clinics may be of definite value: (a) when the patients are well-nourished and strong they may benefit from the walk to the treatment centre, and the injections may be beneficial; (b) when the clinic is used as a centre for the careful individual care of each case, complicating diseases being attended to carefully and only suitable cases being selected for special treatment; (c) when the primary object of the clinic is educational and it is used as a centre of exchange to get in contact with foci of leprosy, the patients being followed up to their homes and contacts examined.

At some of the clinics in the Masasi and Newala Districts of South Tanganyika the patients seemed to be in exceptionally good health. This was probably largely due to the absence of malaria and other complicating diseases in their waterless plateau, and the excellent soil and consequent good nourishment of the people. The results at these clinics were exceptionally promising.

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Compulsory segregation, at least in its most rigorous forms, has been or is being abandoned in all the British territories visited.

In the Belgan Congo compulsory segregation is enforced through the Chiefs, who set aside part of their territory for leper camps. The objections to this system as practised at present are referred to on page 30.

A comparison of the results on the leper island at Bunyonyi (p. 31) with those at Kumi and Ongino (p. 41) illustrates the difference between an institution partially compulsory in origin, and those begun and maintained entirely on the voluntary system.

The abandonment of compulsion in Zanzibar has been followed by a distinct improvement of morale among the patients and by no diminution of numbers. Steps are already being taken towards putting into force the recommendations in the Somaliland report, which include the subsequent transformation of the present system into one on a voluntary basis.

It must not be supposed, however, that the abandonment of compulsion implies relaxation of effort to control leprosy. On the contrary, the only justification for the voluntary system is readiness to set in train much more active, and possibly expensive measures, but working through friendliness and understanding and seeking to win the co-operation of the patients.

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Occupational Therapy is now acknowledged to be of the utmost importance in the treatment of leprosy, as also in other chronic physical and mental diseases. In many of the institutions visited this was recognised to the extent of giving the patients land which they could cultivate if they wished. But with two or three exceptions there was little attempt at organisation of labour, encouragement to lead an active life, or training in industries and other forms of useful occupation.

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Expert Advice to those in charge of leprosy work is much needed in East Africa. Much devoted work is being done, especially by missionaries, which is not bringing in a proportionate return, and this is often only for want of knowing clearly how to go about things. A leprosy expert for East Africa has been suggested, and the British Empire Leprosy Relief Association is willing to bear one-third of the expense involved if the countries concerned will supply the balance.

Education has an important bearing on the control of leprosy. As the population becomes leprosy-conscious, the disease tends to diminish. Much could be done by or through the educational authorities in teaching the public the nature of leprosy and the very simple precautions necessary for its prevention. The suggestion of Bishop Lucas regarding initiation rites (p. 79) is one worthy of trial.

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One of the most common objections put forward by public health authorities to an active campaign against leprosy is that leprosy will only disappear when amelioration of general conditions and improvement of the standard of living have taken place. Against this may be urged that an active campaign against leprosy may prove, as it is doing in Eastern Uganda (p. 41), one of the most potent means of raising the general life of the people.

(Notes on *Treatment*, *Education* and a *Leprosy Expert* are added at the end of the Reports (pp. 100-102), as these have common reference to several of the countries visited).