ZANZIBAR

HISTORY

From 1921 up to the beginning of 1936 lepers in Zanzibar and Pemba were compulsorily segregated in a settlement on Funzi Island, lying off the West Coast of Pemba. Power to enforce this policy was derived under the Public Health Decree, and after 1926 under the Leprosy Decree, the latter aiming at a policy of rigid segregation. After a visit from Dr. Cochrane, of the British Empire Leprosy Relief Association, in 1930, Dr. Welch was sent out by that body to carry out a survey of leprosy in the two islands. Unfortunately this survey was not carried out and Dr. Welch's services were withdrawn.

In 1935 it was realised that the policy of compulsion was not successful, and also that Funzi Island was unpopular with the lepers and unsuitable for the settlement.

In the beginning of 1936 a new settlement was begun at Makondeni, in Pemba, and patients were admitted on a voluntary basis, Funzi Island Settlement being closed down.

Before 1936 hopeless patients and those in whom the disease had healed up with deformities, were transferred to the poorhouse at Walezo, 4 miles from Zanzibar town. In 1936 a new settlement for lepers was begun adjacent to the poorhouse. Thus there are now two settlements, both voluntary : at Walezo for lepers in Zanzibar Island, and at Makondeni for those on Pemba Island; though patients can, on their own desire, be sent to either of these institutions.

So far the adoption of a voluntary system appears here, as elsewhere, to have been fully justified. The number segregated has not diminished in spite of the fact that some of those on Funzi Island were repatriated to the mainland. Moreover, the patients are more contented, and better results are obtained in the recovery of patients.

PRESENT INSTITUTIONS

Walezo Settlement. On the 24th of July, 1938, I visited the Walezo Settlement in company with Dr. Webb, the Director of Medical Services, and Dr. McCarthy. The settlement is situated on sloping ground separated by a natural barrier from the adjacent poorhouse. Permanent buildings consist of a treatment centre and hospital wards. The patients live in mud and thatch huts scattered throughout their cultivated fields. Daily rations are given to the patients, along with a small monthly allowance

of money which they can spend in a shop within the settlement. They supplement their rations with the produce of their cultivation.

The patients appeared well-nourished and happy, many of them showing good physique. I examined 46 out of the present 53 patients and classified them under 5 headings : open nodular (L_2 and L_3), slightly and doubtful open cases (L_1), cases with tuberculoid macules, those with flat macules, those with no apparent active signs. Unfortunately I was not able to obtain notes of bacteriological findings, though I understand that these are carried out at the Government bacteriological laboratory. The types were also subdivided according to whether they were deformed and disabled, or not :—

Open nodular (L_2 & L_3) ...	Deformed	8		
	Undeformed	13	21	
Slightly & doubtful open (L_1)	Deformed	6		
	Undeformed	2	8	
With tuberculoid lesions ...	Deformed	4		
	Undeformed	2	6	
With flat lesions	Deformed	2		
	Undeformed	1	3	
Without apparent active signs	Deformed	5		
	Undeformed	3	8	
				46

Thus 25 were deformed and 21 undeformed; 21 were open nodular and 8 slightly open, making a possible total of 29 infections, as compared with 17 non-infectious cases. Some obvious complicating diseases were tinea, scabies and entropion, but these were found only in a few of the patients. The patients are fortunate in having the devoted attendance of Sister Frieda Bertha, who also looks after the inmates of the poorhouse and tuberculosis wards. The settlement is under the supervision of the Medical Officer, assisted by a Sub-Assistant Surgeon.

Makondeni Settlement. Unfortunately time did not permit a visit to Makondeni, but I add a few notes on that settlement gathered chiefly from the 1937 Medical and Sanitary Report.

The patients live in huts, and employ themselves, as at Walezo, in cultivation of the land, of which plenty is available. Unfortunately malaria is rife (parasite index almost 50%), but it is hoped to investigate the cause in the near future. There is a hospital building with 6 beds, but patients prefer treatment in their own huts and do not favour the hospital. The water supply is from a well and catchment tanks. At the end of 1937 there were 63 lepers. The District Medical Officer visits from Wete, 4½ miles distant, once a week, and the Nursing Sister two or three

times a week. A trained dispenser on a salary of £72 a year lives on the settlement.

The following table gives the number of patients at the beginning of the year, the new admissions and the deaths for the last five years in the two existing settlements :

Year	*No. 1st Jan.*		*New Admissions*		*Deaths*	
	Funzi	*Walezo*	*Funzi*	*Walezo*	*Funzi*	*Walezo*
1933 ...	92	—	14	—	11	—
1934 ...	93	34	15	8	12	11
1935 ...	91	29	3	18	6	8
1936 ...	53	39	12	23	8	9
1937 ...	63	52	10	18	4	9

The following is the expenditure at the two settlements for the last four years, including the erection of buildings, but excluding the expenditure on staff, drugs and appliances :

Year	*Funzi*	*Walezo*	*Total*
	£	£	£
1934	955 ...	210 ...	1,165
1935	870 ...	281 ...	1,151
1936	1,395 ...	501 ...	1,896
1937	1,189 ...	552 ...	1,741

I am informed that once the necessary buildings and other permanent works are completed, the expenditure will diminish to about ten or twelve hundred a year.

DISCUSSION AND SUGGESTIONS

I was pleased to learn that in both institutions the main emphasis in treatment is laid upon attention to complicating diseases and causes of malnutrition. I know of no other institutions in East Africa where anything approaching the generous expenditure of the Zanzibar Government is reached, being in the region of £10 per year per patient, in addition to free land, house, attendance and drugs. The facilities for exercise in the form of farm work is another excellent feature. At Makondeni " despite the fact that no treatment with chaulmoogra derivatives was given during most of the year, three cases have become bacteriologically negative, clinically arrested, and fit for discharge. Of these, one preferred to remain, and the other two were discharged, However, of the latter, one returned 10 days after leaving the institution and requested re-admission, not because she was ill, but because she said she was happier at Makondeni."

Of the patients I saw at Walezo, very few were suitable cases for special treatment with chaulmoogra or other similar drugs. In most of them the disease was too far advanced, either because of

their massive infection or because of crippling and disablement. Besides this, an indispensable requirement for successful leprosy treatment is a state of mental and physical activity, with hopefulness and independence. As far as I could judge, this spirit appeared to be absent from the institution, and any attempt at active treatment could not be expected to meet with much success.

Judging from the types of cases at Walezo, either the leprosy of Zanzibar must be different from elsewhere, or else there must be considerable numbers of the earlier and milder forms of leprosy outside the settlement. Also, judging from the advanced state of the disease on admission, many patients must have an opportunity of spreading infection in the population before they present themselves.

However, there are three important difficulties in the way of taking more active measures for dealing with leprosy in Zanzibar.

1. Leprosy is only one out of many difficult health problems, and a greater expenditure than that at present would be out of proportion to its comparative importance, considering the funds available for public health.

2. The bad effects of the former compulsory system have not yet entirely subsided, and lepers are still suspicious of any active means for controlling the disease.

3. Zanzibar has a mixed, and, to a large extent, a floating population, very ignorant, prejudiced and conservative, and till education has made more headway public health measures will remain hampered.

The now voluntary system has not yet had time to be tried out fully. I would suggest that the present settlements be made progressively more attractive, in the hope that they will draw more and more voluntary patients; and that, at the same time, the patients be encouraged to cultivate their fields better and support themselves to a greater degree by their own labour. It should thus be possible to admit at least double the number of patients without any increase of expenditure. In proportion as the spirit of independence and hopefulness increases, special treatment might gradually be introduced in suitable cases.

Later, out-patient treatment might be introduced for suitable cases, and educational preventive methods might be included in the general public health propaganda, as elsewhere.

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