

INTRODUCTORY NOTE

This issue of *Leprosy Review* consists of Reports on visits paid by Dr. Muir to seven British territories and the Belgian Congo during a four months' tour in the summer of 1939. In the order visited these countries were : Nyasaland, Northern Rhodesia, Belgian Congo, Southern Rhodesia, Union of South Africa, Basutoland, Nigeria and Cyprus.

OBJECTS OF TOUR

The tour was made on behalf of the British Empire Leprosy Relief Association, and on the invitation of the Colonial Office, the High Commissioner for South Africa and the Medical Departments in each of the countries visited. The itineraries were arranged by the Medical Directors, except in the Belgian Congo. An abstract of the whole tour is attached showing the methods of travel and the places visited.

The objects of the tour were :—

1. To visit as many leprosy institutions as possible and study the methods adopted for treatment and control.
2. To study leprosy as found in each country, the frequency, distribution and type; also to investigate the economic, nutritional, sociological and other factors influencing leprosy.
3. To advise Medical Departments, doctors and others interested in the subject regarding improved methods of dealing with leprosy.
4. To attend the Leprosy Conference called by the Director of Medical Services, Nigeria, and held at Enugu in August, 1939.

In this introductory note an attempt is made to abstract and co-ordinate the various aspects of the leprosy problem as they presented themselves to the writer during his travels. These may conveniently be grouped under distribution, legislation, treatment and research.

DISTRIBUTION

Leprosy is distributed widely over Africa. Only in a few places, such as the dry deserts inhabited by nomadic tribes, is it uncommon. In South Central Africa it is most common in the hot, moist, low-lying land along Lake Nyasa, and the somewhat similar Zambesi basin in Barotseland. Reference has been made (pp.14, 19) to the difference in type of the disease as it exists in

these two places, and possible reasons are suggested for this difference.

The distribution in South Africa is dealt with only in brief. The Report on Mkambati (p.46) shows the frequency to be diminishing in Pondoland, where an anti-leprosy campaign has been intensively carried on for some time; whereas in Zululand it is only more recently that the Amatikulu institution has attracted cases, and control is still at an earlier stage.

One of the most interesting findings is the much more severe type found among Europeans in South Africa (p.43), and in Cyprus (p.70) as compared with the Bantus both in the Union and in the Rhodesias. The reason for this is not at all clear.

The wide-spread distribution in Cyprus is of interest, the 188 known cases being scattered through 91 families and 56 villages all over the island.

LEGISLATION

Among the countries visited there exists the widest possible divergence of methods of control. In the Union of South Africa leprosy is counted as a major problem. During the last 20 years between two and three million pounds have been spent on its relief and control (p.48). A compulsory system has been adopted, but the rigour of this system has, at least in the native reserve areas, been modified by the willing co-operation of the people themselves (pp.45, 49). This system, though expensive, is gradually leading to the elimination of the disease.

Basutoland, surrounded as it is by Union territory, has adopted similar legislature. Here, too, the expenditure has been high, but there is reason to believe that the measures adopted are proving gradually effective (p.42).

In Cyprus also compulsion is in force (p.73); but there expenditure has been restricted and there has been the absence of a far-sighted policy which might ere now have brought the disease under control. Methods have been suggested which it is hoped will soon master the disease and eliminate it from the island.

Southern Rhodesia resembles its neighbour South Africa in supplying leprosy institutions owned and financed by Government; but so far no widespread attempt at compulsory segregation has been made. The reason for this is not that leprosy is a less serious problem, but probably that the country has been more recently developed, and is as yet less wealthy. Also leprosy has not yet become as frequent a disease among the European population as it has in South Africa.

In Northern Rhodesia, Nyasaland and Nigeria the great

majority of the leprosy institutions are on the basis of a partnership between the administration and missions, the former supplying a greater or less part of the funds, and the latter supplying the balance of the funds and undertaking the responsibility for the work. In these three countries the mission-run institutions are of two widely different kinds: those with whole-time medical, nursing and lay European staff, such as the Itu, Uzuakoli, Oji River and Ossiomo institutions; and those in charge of a nurse or lay worker and with little or no medical supervision. The International Leprosy Congress at Cairo adopted among its resolutions that :—

“ Voluntary organisations have in the past, and can in the future, aid greatly in anti-leprosy work. It should be emphasised, however, that the control of leprosy is the inescapable responsibility of the governments concerned.”

In Nigeria the larger institutions just referred to show what excellent work can be done by mission-government co-operation; but in Nyasaland and N. Rhodesia the small institutions, though doing noble relief work, are of little value towards the ultimate control of the disease. One reason for this is here, as elsewhere in Africa, the poverty of the country. But, as has been shown in the reports, a great deal more could be done with little additional expenditure. In the past a much more important reason has been that leprosy does not obtrude itself as an urgent problem like malaria and sleeping sickness, and there is apt to be wishful reasoning that as the general standard of hygiene and nutrition improves leprosy will disappear. The fallacy of this argument is pointed out (p.65).

TREATMENT

Leprosy still lacks what may be called a specific remedy, and on this account considerable skill and experience are necessary to obtain the best results. In most of the institutions visited there was considerable room for amendment in the methods used. The improvements suggested may be divided under mental, mobilization, complicating diseases and typing.

Mental. The first essential for the treatment of leprosy is to provide the right social atmosphere. If the patient is discontented or lazy or non-co-operating; if his self-respect has been lost and not regained, then treatment is badly handicapped. In some places (p.21) leprosy was looked upon as a privilege rather than a curse. The mental aspect of the question is very fully recognised in some but not in all of the institutions visited.

Mobilization. Reference has been made repeatedly in most of the Reports to the importance of mental and physical activity.

and the use of occupation therapy, well-regulated physical exercises, baths, etc. A trophic ulcer frequently interferes with the patient's activity; as he cannot walk freely or take exercise the disease becomes aggravated. The importance of immediate operation to relieve the condition is discussed on pages 47 and 50. In most institutions a large proportion of the patients were found to be chronic invalids, largely as a result of palliative, as opposed to more radical, treatment of such ulcers.

Complicating diseases. Not less important is the treatment of complicating disease. In reports on several institutions reference has been made to treatment of diseases of dirt, such as scabies and various mycotic and septic infections, to eye complications such as trachoma (pp.53, 55, 64, 74), to malnutrition, anaemia, malaria and various parasitic infestations.

Typing of Cases. Great confusion was found in almost all institutions visited regarding the typing of cases, and the significance of the types in treatment, prognosis and control. It was not realised that many early neural cases will heal up in a few months under intradermal injections of chaulmoogra (pp.24, 27, 33, 41, 50). Also the diffuse infiltration lesions of the lepromatous type were not recognised, and too much stress was laid on the bacteriological examination of the nose to the exclusion of skin smears.

Attention to these few points should speed up recovery of many cases, prevent the milder type from degenerating into the more severe (pp.41, 45) and make anti-leprosy treatment more popular. Above all, individual attention to each case is necessary, and it must be understood that considerable medical skill, both special and general, are necessary to get favourable results in leprosy.

RESEARCH

It is important that research should be kept in the forefront of the plan of all well-equipped leper settlements. The main advance that has been made in our knowledge of leprosy in the last twenty years has been in the field and the clinic, rather than in the highly equipped laboratory. And the main chance of advance in future is likely to be based chiefly on the work of the whole-time leprosy doctor with his unique knowledge of the habits and customs of primitive peoples, and having at hand the rich clinical and epidemiological material of a leper settlement.

An editorial in the last issue of *Leprosy Review* suggested many of the subjects which require investigation.

The writer wishes to express his thanks to the Governments and Medical Departments of the various countries visited, and especially to the Medical Directors who drew up the itineraries and made the principal arrangements for transport and visiting the various centres, to the medical and administrative officers, missionaries and others who supplied hospitality, arranged visits to leprosy and other institutions and spared no pains in making the tour interesting and useful.

ITINERARY

- May 27 Left England by Imperial Airways.
- June 1 Arrived Blantyre, **Nyasaland**.*
- „ 2-14 Visited Nyasaland leper institutions at Malamulo, Likwenu, Utale, Mua and Loudon, the Jeanes School, the Nutrition Research Centre at Chintembwe, and made a short survey in the region of Salima.
- „ 15 Arrived Fort Jameson in **Northern Rhodesia**.*
- „ 16-17 Visited Mwami and Nsadz Leper Settlements.
- „ 18 Fort Jameson—Lusaka by Air.
- „ 19-20 Visit to copper mines at Nkana and Roan Antelope.
- June 23-July 3 Visit to Bibanga, **Belgian Congo*** (rail and motor).
- July 4 Toc H meeting, Ndola.
- „ 5 Fiwila Leper Settlement.
- „ 6-8 From Kapiri and Broken Hill to Mongu and Balovale in Barotseland, and back to Lusaka by air.
- „ 9-11 To Livingstone and Victoria Falls.
- „ 12-13 To Salisbury, via Bulawayo, **Southern Rhodesia**.*
- „ 14-21 Visits to Mtoko and Ngomahuru and on to Beitbridge.
- „ 22-26 At Pretoria and Johannesburg, **Union of South Africa**.
- „ 26-30 At Botsabelo, **Basutoland**. Travel by train and motor.
- July 31-Aug. 8 At Emjanyana (Transkei) and Mkambati (Pondoland) Leper Settlements. Travel by motor.
- Aug. 9-12 At East London. Spoke to Toc H and Medical Society and Rotary.
- „ 12 To Durban and Elandskop.
- „ 15-16 At Amatikulu Leper Institution (Zululand).
- „ 17-21 Durban to Kano, **Nigeria**, by air, via Khartoum.
- „ 21 Visit to Yada Kunyu Leper Settlement (Kano).
- „ 22-24 At Zaria Leper Settlement.
- „ 25 To Oji River Leper Settlement by train and motor.
- „ 26-27 At Oji River.
- „ 28-30 Leprosy Conference at Enugu.

- Sept. 1-3 At Uzuakoli Leper Settlement.
 „ 4-7 At Itu Leper Settlement..
 „ 8 At Ossiomo Leper Settlement.
 „ 9 At Ilesha Leper Hospital.
 „ 10 At Ogbomosho and to Lagos by motor.
 „ 11 At Lagos—medical meeting.
 „ 12-15 Lagos to Khartoum, **Anglo-Egyptian Sudan**.
 „ 16 Omdurman Leper Clinic.
 „ 19 Khartoum to Cairo.
 „ 20 Cairo to **Cyprus** (train and steamer).
 „ 21-26 Cyprus—Leper Camp and tour round island.
 „ 26 Cyprus to Alexandria, by air.
 Sept. 27-Oct. 2 Alexandria—England.

* The institutions visited in Nyasaland, the Rhodesias and the Congo● are indicated by numbers on the map.



FIG. 2.

UTALE INSTITUTION: father and mother are advanced lepromatous cases; what chance has the child?