FUTURE PROGRAMME OF B.E.L.R.A.
A Progressive Plan for the Control of Leprosy in the British Colonies

By E. MUIR

There are definite reasons why the British Empire Leprosy Relief Association should think out carefully and formulate, at the present time, a plan extending over a period for the control of leprosy in the colonies. During the world war all ordinary peace-time medical and social progress has been in abeyance. With peace in prospect there will soon be an opportunity for a fresh start.

The Colonial Development and Welfare Scheme is offering assistance with the relief of leprosy in proportion to its importance as a medical and social problem. Private bodies, such as B.E.L.R.A., the Leonard Wood Memorial in America, and the Mission to Lepers, are at present raising funds which should make it possible to expand anti-leprosy activities when the time comes. Not at present, but in the immediate future, doctors, nurses and social workers are likely to become available for this kind of work.

Even during the war years advance has been made in our knowledge, especially in the finding of new drugs which, in the opinion of those who have tested them, make possible a definite step forward in treatment. Intensified investigations are all the more called for, especially along the lines of improving treatment, field investigation, and methods of prophylaxis.

With these possibilities in view, it is well to be prepared beforehand, so that time and energy may not be wasted for lack of forethought and co-ordination.

The Nigerian Government has promulgated a five-year plan beginning in April, 1945, based in general upon the recommendations of the Medical Secretary of B.E.L.R.A., made in 1936. The plan is as follows :

1. A Senior Leprosy Officer will be appointed who will supervise and inspect leprosy work, organise investigation and surveys and research, train staff, and prepare future plans.

2. Leprosy organisation will continue on a provincial basis in those provinces where this method has already been developed, and this method will gradually be extended to other provinces.

3. There will be a leprosy service consisting of (a) a permanent cadre of experienced Medical Officers, Nursing Sisters and Leprosy Control Officers appointed on the usual terms of the Colonial Service ; (b) a permanent cadre of nurses, dispensers, clerks, inspectors, and subordinate personnel on approved Native Administration rates ; (c) a temporary cadre of leper patient staff.

4. The provincial work will have the following institutions :

(a) one or more leper settlements ; (b) clinics for treatment of non-infectious cases and for educating the villagers ; (c) clan segregation villages on the lines at present in force in the Owerri Province ; (d) homes for incurable cases, for new-born uninfected children of leprous patients, and for children of patients who have no healthy relatives. While Government will undertake the financial responsibility for the above, taking over the existing doctors and Toc H lay-workers, the policy is that the missions, or other authority formerly in charge, should continue to be responsible for social, educational welfare, and religious activities.

5. Government will take over responsibility for the service in Onitsha, Owerri, and Benin Provinces and consolidate it on a permanent basis.

6. The plan will include the Western Provinces after preliminary surveys and investigations have been made, and gradually the work in this area will be consolidated.

7. The five-year plan is as follows :

1944/45

(a) Appointment of Senior Leprosy Control Officer and creation of Central Leprosy Control Unit. Initial general organisation in selected provinces and investigation in Western Provinces.

(b) Taking over and expansion of existing institutions, settlements, and clinics, with existing trained staff, in the following provinces : Benin-Warri, Onitsha, Owerri.

(c) Commencement of construction of new settlements in South Owerri and in Warri.

(d) Engagement and training of technical staff for new settlements.

1945/46

(a) Consolidation of organisation.

(b) Commencement of construction of a new Control Settlement in Western Provinces.

(c) Engagement and training of staff for Western Provinces.

1946/47

(a) Active prosecution of prevention and treatment in selected provinces.

(b) Consolidation of new organisation in Western Provinces.

1947/48

(a) Active prosecution of measures in all selected provinces.

(b) Assessment of results in these areas ; special re-surveys of sample areas.

(c) Survey of new areas to be brought within the scheme.

1948/49

(a) Preparation for plans for extension of work in new areas.

(b) Revision of plans and estimates for maintenance of work in the original selected provinces at the end of five year period, based on assessment of results obtained.

The five-year plan will provide a leprosy treatment and preventive service for a population of 6,000,000 in densely populated areas of the country, in some of which intensive survey has shown that the incidence of the disease averages 50 per mille of the population (Owerri Province). There are, at present, only some 17,500 of the total leper population receiving treatment, many without that consistency and regularity which is necessary to give hope of arresting the disease. The problem is one of very great magnitude, and steps must be taken to diminish the spread of the disease. The five-year plan, as submitted, was estimated to cost, on an average, £47,000 per annum over the five year period, or 1.88 pence per caput of the population, with a total capital expenditure of £49,000, or 1.96 pence per caput.

The Secretary of State for the Colonies has approved a grant of £258,000 from the Colonial Development and Welfare vote to cover the capital and recurrent costs of the scheme over a period

of five years. From April, 1945, onward, B.E.L.R.A. will hand over to the Nigerian Government the financial responsibility of two doctors, two nurses, and five lay-workers, thus saving a total amount of £3,500 a year. This, along with increased income from subscriptions and donations expected this year, should make it possible for B.E.L.R.A. to engage fresh personnel and undertake new work whenever demobilisation after the war makes that possible.

Before surveying the most urgent work waiting to be done in the control of leprosy in the Colonies, it may be well to define the functions of B.E.L.R.A. alongside of those of Government, and also of other voluntary societies.

1. Leprosy work does not appeal, or has not in the past appealed, to more than a small fraction of those recruited for the Colonial Medical Service. Because of the nature of leprosy and the peculiarly altruistic type of service required, the recruitment of personnel can be more satisfactorily undertaken by a voluntary body like B.E.L.R.A., with the help of Toc H and Missionary Societies.

2. The training of personnel is another very important item which, because of its specialisation and long experience of this disease, and its intercolonial and international contacts, B.E.L.R.A. can more satisfactorily undertake than Government.

3. For similar reasons, B.E.L.R.A. has, in the past, taken a leading share in carrying out and co-ordinating research, in advising and initiating new methods of dealing with leprosy, and in stimulating interest and development along improved lines. There will be ample room for such activities in the future.

The International Leprosy Congress in 1938 adopted unanimously the following resolution :

> " The maintenance of leprosaria should not be continued indefinitely by voluntary agencies, but should increasingly become an obligation of governments, and in new projects, governments should themselves undertake financial responsibility, though their management can often best be undertaken by voluntary organisations. There is also considerable scope for such organisations to work out the most suitable types of institutions for the particular countries concerned, and the best methods for their administration. The development of preventoria for children of leprous parents who are open cases may be mentioned in this connection ; these should be generously supported by the Government. There will probably always be a need for social work among patients, both in and out of institutions, for which the Government will have difficulty in making provision."

The policy of B.E.L.R.A., both in India and in the Colonies, has been to initiate anti-leprosy work and demonstrate results in the hope that the government concerned, after approving these results, would make itself responsible for consolidating what had been done and carrying it on permanently. This has, to a large

extent, been found a successful method, first in India and now in Nigeria. It is suggested that a similar method be followed in future in other regions where an adequate anti-leprosy policy has not yet come into force.

To sum up, B.E.L.R.A. will, in conjunction with Toc H and with the help of missionary societies, recruit personnel—doctors, nurses and lay-workers, whenever they are required and suitable candidates are available. It will arrange for their thorough training, both in England (when deemed advisable) and in suitable centres abroad, providing, where necessary, scholarships, accommodation and equipment for this purpose. During the period of training they will be expected to give any help of which they are capable in the places where they are located. After training, they will either be sent to suitable centres to work under B.E.L.R.A. or in Mission institutions, or be seconded, or handed over to Colonial Governments to be drafted into a Colonial Leprosy Service. With the help of such personnel, B.E.L.R.A. will, as far as possible in co-operation with Missions, develop fresh work in regions which require such development, devising methods suited to the local needs, in the hope that the local governments will later, where necessary and advisable, take their share in consolidating and carrying on approved units on a permanent basis.

The following is a rough survey of the more important requirements as regards leprosy in British Colonies and Territories. The countries considered are, as far as is known, in order of importance and likelihood of a programme being carried out : Nigeria, Southern Sudan, East Africa, Gold Coast, Sierra Leone, Gambia, British Somaliland, Nyasaland and Northern Rhodesia, South African Protectorates, Southern Rhodesia, West Indies, Cyprus, Malta. Other colonies such as those of Malaya and the South West Pacific should also be kept in mind.

1. **Nigeria** has far more leprosy than all the other British African territories put together and, even deducting the regions already planned for, will require more personnel and more effort than any other. Along with India it will also form the most important training ground for new personnel. In the Northern Provinces, apart from Zaria, anti-leprosy work is chiefly in the hands of American Missions. A doctor, a nurse, and one or two lay-workers, subject to the programme of the C.M.S., could be usefully employed in the Zaria centre. For the rest of the Northern Provinces, I suggest that, in the meantime, the responsibility should remain with the three or four missions at present in charge of settlements, and that it might be appropriate

that the American Mission to Lepers should give whatever extra financial help is needed. Their personnel might be trained at the leprosaria in Eastern Nigeria, and B.E.L.R.A. might give considerable help to Northern Nigeria by arranging for such training.

In the Western Provinces, the Nigerian Government's five-year plan undertakes surveys and the establishment of provincial anti-leprosy units. In the course of the next five years it may be expected that at least three doctors, three nurses, and six lay-workers will be required.

In the Eastern Provinces during the same period, having respect to the development of present work and the initiation of a unit in the Ogoja Province, four doctors, four nurses, and perhaps six to eight lay workers may be needed during the same period. With the present workers, this would mean seven doctors, five nurses, and up to sixteen lay-workers.

If B.E.L.R.A. is to undertake the responsibility of training them, money must be set aside for increased accommodation for those being trained, and also for scholarships for those under training.

2. **Southern Sudan.** The equatorial Province of the Anglo-Egyptian Sudan shows a high incidence of leprosy. The large Government Leper Settlement at Li Rangu requires at least one lay worker and a whole-time doctor. To the east of the Nile, the Church Missionary Society has done a certain amount of work, assisted by one of our lay-workers. There should, however, be at least a whole-time doctor, a nurse, and two lay-workers in that region. This would make a survey and the establishment of clinics possible. Further developments would depend upon the results of the survey. Work should be done in collaboration with the C.M.S.

3. **East Africa.** Included under this heading are Uganda Kenya, Tanganyika Territory and Zanzibar. Much work is being done by various Missions in these territories, chiefly in the form of Leper Settlements or Homes. In not one of them, with one recent exception, is there a whole-time doctor and, due to the pressure of other work, the medical supervision is very inadequate. Except for the work at Kumi and Ongino, and the U.M.C.A. in S. Tanganyika, little has been attempted in the line of surveys or control. In many of the larger institutions non-lepers are allowed to live alongside of the patients, and it is questionable if, under these circumstances, the effect of the institution is more infective or preventive.

As recommended by the Medical Secretary of B.E.L.R.A. in

1938, a leprosy expert should be appointed for East Africa, and until this is done there is not likely to be much real progress. There is not much prospect of such an appointment until after two years on account of the shortage of doctors due to the war. B.E.L.R.A. has so far supplied two lay workers to Tanganyika, one in the north and the other in the south. These should be continued if desired by the Government. The policy of the Tanganyika Government, according to a memorandum drawn up in 1938, is to continue to support the existing institutions, but to concentrate on one large industrial and agricultural settlement which would, as far as possible, be run on self-supporting lines. Once this has proved a success, others could be added later. In a poor land of low average fertility, huge extent and population, the problem is a particularly difficult one.

In Tanganyika, in addition to two more lay-workers, B.E.L.R.A. might supply to the Missions concerned the salaries of two or three nurses, to be appointed by the Missions and approved by B.E.L.R.A. In Uganda and Kenya, two nurses and two lay workers might be supplied.

In all three countries during the next two years, until an expert doctor is appointed, non-recurring grants might be made for approved purposes, and applications for the support of nurses might be considered.

4. **The Gold Coast.** Before any definite plan can be formulated an extensive survey must be undertaken. In 1936, I suggested that sample surveys would take at least two years if carried out by an expert doctor, assisted by two lay-workers. I consider that this is the minimum survey which would be of permanent value, and even this would be wasted unless arrangements could be made for permanent units. The form and location of these units should not be determined until the survey has been undertaken.

5. **Sierra Leone.** I suggest that a similar survey be made as for the Gold Coast. It would probably take about the same time, using similar personnel.

6. **Gambia** is a much smaller colony. I understand that the Bishop has in prospect personnel either ready or in course of training in England. B.E.L.R.A. might arrange for the training of a doctor and possibly lay-workers and, after working out an approved scheme with the Bishop and the local authorities, make suitable grants to promote the work.

7. **British Somaliland.** At the request of the Colonial Office I visited this country in 1938. In conjunction with the Senior Medical Officer and the District Officer, I approved a site

for an agricultural leper settlement in the high, healthy plateau bordering on Abyssinia. Before any action could be taken the war came and British Somaliland was overrun. A carefully-chosen and well-trained lay-worker could undertake the founding and running of such a settlement, and at the same time conduct surveys. The success of such a scheme would partly depend on collateral work by the Abyssinian authorities, as the neighbouring Harrar Province of Abyssinia shows a high incidence of leprosy and there is much coming and going between the two countries.

8. **Nyasaland.** Here there are nine small institutions which had, in 1939, a total population of between 400 and 500 patients. They are in charge of various missions, aided by an annual grant of £900. There should be two institutions, one for the north and one for the south, so that more concentrated work could be done. To begin with, one whole-time trained doctor should be appointed who could make surveys, improve the existing institutions, and concentrate upon one larger colony. He should have as his assistant a trained lay-worker.

9. **Northern Rhodesia.** In 1939, the number of lepers was calculated at 6,748 in the five provinces, of which more than two-thirds were in the Western Barotze Province. There are seven small institutions with between 400 and 500 patients. To begin with, one large institution should be formed, under the charge of a well-trained lay-worker, as suggested in my report. If a whole-time doctor were appointed for Nyasaland, he might later spend part of his time in Northern Rhodesia, advising the various missions on the running of their settlements.

10. **South African Crown Protectorates.** In Basutoland, the control of leprosy is well in hand. Recently, B.E.L.R.A. has supplied a well-trained lay-worker for Swaziland. We should be prepared to give further help when required in training or supplying trained personnel. Leprosy is considered a minor disease of no great importance in Bechuanaland.

11. **Southern Rhodesia.** I understand that the Government of this Crown Colony does not require outside help with leprosy at present.

12. **West Indies and British Guiana.** I understand from the Medical Adviser to the Comptroller of Development and Welfare that three suitable doctors for leprosy work could be absorbed under their fund. The British Guiana Government have asked for a lay-worker for welfare work in the Mahaica leprosarium.

13. **Cyprus.** At the time of my visit in 1939, the Cyprus Government would have welcomed an expert doctor who could carry out a survey of leprosy and, at the same time, of other

diseases. Possibly B.E.L.R.A. could pay part expenses of such a scheme. A lay-worker for the leper camp would also be useful.

The above scheme is very rough and sketchy and is put forward in the hope of receiving criticism and suggestions from the governments, missions, and others concerned. However little can be done in the near future, it should at least be possible to formulate a leprosy policy in each colony, with rough estimates, so that as personnel and funds become available, progress may be made.